

# **MEDICARE PHYSICIAN PAYMENTS: 2007 AND BEYOND**

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HEARING  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON ENERGY AND  
COMMERCE  
HOUSE OF REPRESENTATIVES

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# **MEDICARE PHYSICIAN PAYMENTS: 2007 AND BEYOND**

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**THURSDAY, SEPTEMBER 28, 2006**

HOUSE OF REPRESENTATIVES,  
COMMITTEE ON ENERGY AND COMMERCE,  
SUBCOMMITTEE ON HEALTH,  
*Washington, DC.*

The subcommittee met, pursuant to notice, at 2:00 p.m., in Room 2322 of the Rayburn House Office Building, Hon. Nathan Deal [Chairman] presiding.

Members Present: Representatives Deal, Upton, Norwood, Cubin, Shimkus, Shadegg, Ferguson, Burgess, Barton (ex officio), Pallone, Green, Capps, and Dingell (ex officio).

Also Present: Representative Price.

Staff Present: Ryan Long, Counsel; Brandon Clark, Policy Coordinator; Nandan Kenkeremath, Counsel; Chad Grant, Legislative Clerk; William O'Brien, Research Analyst; Amy Hall, Minority Professional Staff Member; and Jonathan Brater, Minority Professional Staff.

MR. DEAL. The Chair will call this hearing to order. We have a very distinguished panel today that are going to talk about a subject which I think is certainly timely and appropriate, and that is Medicare Physician Payments: 2007 and beyond.

You, as a panel, will represent the physician community, the quality improvement community, as well as the beneficiary community. I must tell you in advance that I am not just skipping out on you, because after I give my opening statement I am going to have to leave. We have the children's healthcare graduate medical education bill that is on the floor that I have to handle. Then we have the Ryan White reauthorization, which will be on the floor immediately after that. So I think you all recognize those are important issues we would like to get moving.

This hearing is intended to provide a forum for our committee members to consider legislative proposals for physician payment for 2007 and subsequent years, including the importance of controlling for high growth and volume and the intensity of physician services, as well as the promotional quality of physician care.

To this end the committee has prepared a discussion draft that sets forth some of the fundamentals for reform. We would like to consider advancing in the short term a multiyear stabilization of physician

payments with a bonus payment for participation in utilization management and quality programs.

As my colleagues on this committee are no doubt aware, we are the committee of primary jurisdiction on the issue of Medicare physician payments. Without questions, this is an issue that is one of the most important and challenging legislative initiatives we must undertake and hopefully in some fashion conclude before the end of this Congress.

As always, I look forward to having a cooperative effort with our colleagues on the other side of the aisle, and hopefully we can work together to find a solution that is going to be an effective legislative solution to what has been a very long-term ongoing problem. I would like to thank all of the witnesses in advance who are here, and if I can speed things up on the floor, I will at least maybe get to hear some of you when I return.

I am going to at this time turn the gavel over to our vice chairman of the Health Subcommittee, Mr. Ferguson of New Jersey. In the meantime, I would like to ask unanimous consent that all members would be allowed to submit statements and questions for the record. Without objection, it is so ordered.

While Mr. Ferguson is coming, I will at this time recognize Mr. Dingell, who is, of course, the Ranking Minority leader. I will recognize him for his opening statement for 5 minutes and turn the gavel over to Mr. Ferguson.

[Prepared statement of Hon. Nathan Deal follows:]

PREPARED STATEMENT OF THE HON. NATHAN DEAL, CHAIRMAN, SUBCOMMITTEE ON  
HEALTH

- The Committee will come to order, and the Chair recognizes himself for an opening statement.
- Today's hearing is entitled "Medicare Physician Payments: 2007 and Beyond," and I am pleased to say that we will be hearing from an expert panel of witnesses representing the physician, quality improvement, and beneficiary communities.
- This hearing is intended to provide a forum for Committee members to consider legislative proposals for physician payment for 2007 and subsequent years, including the importance of controlling for high growth in volume and intensity of physician services and promotion of quality, efficient care.
- To this end, the Committee has prepared a discussion draft that sets forth some of the fundamentals for reform we would like to advance in the short term – a multi-year stabilization of physician payment with bonus payment for participation in utilization management and quality programs.
- As my colleagues are no doubt aware, this Committee is the committee of primary jurisdiction on the issue of Medicare physician payment, and without question, this issue is one of the most important and challenging legislative tasks we will undertake.
- As always, I am looking forward to having a cooperative and productive conversation on this topic today and to working with my colleagues on both sides of the aisle to produce an effective legislative solution to this ongoing problem.

- Again, I would like to thank all of our witnesses for participating today, and we look forward to hearing your testimony.
- At this time, I would also like to ask for Unanimous Consent that all Members be allowed to submit statements and questions for the record.
- I now recognize the Acting Ranking Member of the Subcommittee \_\_\_\_\_ for five minutes for his/her opening statement.

MR. DINGELL. Mr. Chairman, you are most courteous, I thank you, and I commend you for holding this hearing. I look forward to hearing again the testimony of organizations represented at this hearing regarding the Medicare physician payment cut.

I note this is the fifth hearing in 12 months this committee has held on physician payment issues. On these matters, I think the doctors feel a little like we used to when we were in the Army. We had a song we sang, which said, I am forever signing the payroll, but I never get a damn cent.

What we need now is action. The doctors are entitled to adequate Medicare payments. They are grateful, I am sure, for hearings, but they need action. Given the late date and with no legislation being marked up in this committee, it appears that the Congress has neglected our responsibility to provide a remedy for the anticipated 5.1 percent cut which will take place early next year.

I am not critical of my colleagues on this committee, but there is an abundance of criticism available which can honestly be made against the budgeteers, the Appropriations Committee, the Administration, the Department of Health and Human Services, and the White House.

Even if a remedy is eventually enacted, this lack of progress indicates not only uncertainty for both beneficiaries and their doctors, but also for the system, and it will threaten, indeed, the delivery of health care services to our people in all areas. It also shows a supreme lack of congressional leadership on an issue that everybody has known about for years, that has been looming and for which holding hearings has become a response rather than a solution.

Of course, some will say paying physicians adequately will cost too much. That is a lot of malarkey. They are entitled to decent treatment. But there is an easy, simple solution that we can apply here. Why don't we just shift some of the billions in Medicare overpayments that are now made to HMOs so that we can pay adequate wages to doctors and health care providers? There is absolutely no reason why HMOs should receive more generous payments than a senior's doctor, excepting, perhaps, that they have more expensive, more and better lobbyists, who have better access to the Administration.

We should ensure fairness and fiscal integrity by creating a payment system that adequately compensates providers, whether they are HMOs or physicians. Simple justice says we should do no less.

If Congress does belatedly act to improve physician payments, we must do so without increasing Medicare patient premiums. That is quite unnecessary in view of the fat hog that our friends at the insurance companies are cutting. To those who say it would be too expensive to protect beneficiaries, I say it would be too expensive not to protect beneficiaries, and failure to protect them is far too costly for us to accept.

More hardships would clearly fall on seniors and people with disabilities who live on fixed income if we don't do something about this and do it soon.

I note that some of the Congress believe that if Congress increases physician payments this year, it must include an intricate and complex system for reporting quality data that is called pay-for-performance. But if we need pay-for-performance, there is time to develop it, but let us develop it right, and let us not hold these matters hostage to that.

We would be hard pressed, I believe, to enact such an ambitious system in the time remaining, at least not in a careful, thoughtful and well-done way. The physician payment system, as I have said, should not be held hostage to it.

While such a reporting system is a laudable goal, we must ensure that this system is crafted with care, with thorough collaboration and cooperation with the medical community. Otherwise we are very likely to end up causing more harm than good for all concerned, providers and beneficiaries alike.

There is a way here to do this right. I, along with my colleagues on this side of the aisle, have introduced H.R. 5916. It would provide a 2-year period of stable payments for Medicare providers. This bill would allow ample time for Congress to explore issues associated with the quality reporting data; for instance, pay-for-performance, and it would help us develop a system that is meaningful to providers, as well as offering the right incentives for care. We need to work on a bipartisan basis, and we have done so in this committee, as you well know, Mr. Chairman.

If we are to succeed in this in the remaining time, we have no choice but to do so. Failure to do so offers fine opportunities for great troubles, not only currently, but in the future, and it will threaten the entire system of health care in this country. We have to work with provider groups, beneficiary organizations, policy experts to create a fair and patient-centered quality reporting and a pay-for-performance system. This is going to require a longer timeframe and will delay very important business that must be done more immediately.



In the meantime, we can't delay in devising a remedy for the coming physician pay reductions, because they are very much in the offing, and will have still worse consequences. Let us then act immediately to stabilize Medicare payments to doctors to protect premium increases for patients while Congress explores longer term issues.

We have the talent, we have the public support, we have the justice of the matter on our side. I beg you, Mr. Chairman, let us begin. Thank you for your kindness.

MR. FERGUSON. [Presiding.] Thank you for your opening statement. Medicare physician payment is an issue that demands our attention because it directly affects the abilities of our Nation's physicians to provide care. If we fail to act by the end of this year, physicians will see a cut of almost 5 percent in payments for Medicare.

If the SGR were allowed to continue to be applied in subsequent years, the cuts would continue to mount by as much as 37 percent by 2015. As physician payments go down, practice costs during the same period are expected to increase 22 percent. As medical liability premiums spiral upwards and the baby boomers approach Medicare age, we cannot cut the legs out from under our doctors by slashing their Medicare payments.

The SGR is fatally flawed, and, as I have said in the past, it is time that we start writing its obituary today. I think the ideas that have been put forward on both sides of the aisle, I particularly appreciate Chairman Deal's leadership, Chairman Barton's leadership. I think they have put together some important principles and ideas. I am hopeful and optimistic that we will make progress, and I am particularly interested to hear today from this distinguished panel of witnesses. It is your expertise, opinions, suggestions, thoughts, and ideas which will be crucial to us as we craft a product which will help to address this problem. So I appreciate you being here today.

I recognize Ms. Capps for an opening statement.

MS. CAPPS. I thank you, Mr. Chairman, and I want to say first that one of our colleagues, Bart Gordon, wanted to acknowledge that he would have intended to be here, would like to be here, but is involved in a Science Committee markup or hearing and will submit a statement for the record. I have a feeling that there are many of our colleagues who are not here, not because they are not interested in this topic, but because of the press of the last couple of days of being here.

We have an esteemed panel of witnesses, and I want to move quickly to get to the hearing, to the testimony that you all want to give. But I do want to say that I think there is agreement in this Congress that we need to reform the current Medicare physician reimbursement system. In fact,

as my ranking member has mentioned, we must all agree because now we have had five hearings on the very same subject in this very year.

So, sitting in this room today, I have this overwhelming sense of *deja vu*. We are about to hear yet again about the very real problems we know are facing physicians and beneficiaries. But we have only a day or two left before we break for recess. Quite frankly, holding this hearing at 2:00 p.m. today without any confirmed plans to bring corrective legislation to the floor makes this an exercise of which I question its value.

We know what needs to be done. We know that the SGR formula is fundamentally flawed, needs to be scrapped so that we can develop a better system. We know that we cannot allow the impending 5.1 percent decrease in reimbursements to occur, and I want to echo my support or give my support to our Ranking Member Dingell, who has introduced a very smart piece of legislation cosponsored by all Energy and Commerce Democrats which takes the important first steps and would provide doctors with a fair update in payments for 2007 and protect beneficiaries from increased premiums.

We certainly should be able to do this, to start with. It sets the stage also for a long-term solution that does not rely on enacting these last-minute, one-year updates that really do threaten the future of the whole system and also threaten long-term solvency concerns.

As I have said, we already know what needs to be done to fix the yearly update system. I want to urge our Chairman to move on to another related subject that deserves its own hearings and its own fix, and that is the geographic adjustment issue. I know that is on the minds of many of you here. Even though you have been asked to testify on the different topics, they are very related.

I have brought this up before in this committee, and I will continue to do so, because it is something that many of my colleagues here know about firsthand from the physicians and providers in their districts. We should be more vocal about this on your behalf, including our Chairman, Mr. Deal, because his district is affected more greatly than many of the rest.

But 175 counties, in 32 different States, where physicians are paid, this is the number, there are that many counties where physicians are paid 5 to 14 percent less than their Medicare-assigned geographic cost factors because they are assigned to inappropriate localities. My own district knows this very well. Santa Barbara and San Luis Obispo Counties in California currently receive reimbursements much lower than the geographic cost factors for those counties. Add to that, add to that the overall cut in payment, you wonder why any of them stay in

practice. There are proposals out there but none of them have really been acted on.

I want to take this opportunity to stress how important a fix would be to so many of our constituents. It is really heartbreaking to me as I hear physicians closing up shop, beneficiaries who can't find a doctor who will take a new patient on Medicare. This is happening more and more across this country.

With each physician who leaves, a number of patients are left then to find new doctors, wait longer for their appointments, travel further for their visits. This is a very fragile population to begin with. We are really not stepping up to meet this challenge. We can't allow this to go on any longer.

I want to call out, I know we have a family practice physician among those testifying today. I am a nurse, and I have worked hard since I have been in Congress to deal with the shortage of nurses. They are related. Some of the factors are related, and I find it interesting that we had a demonstration here on Capitol Hill by family practice physicians yesterday. I know about it because one of our former colleagues, Congressman Gansky from Iowa, a physician himself, came with his wife, who is a family practice physician. This shortage that was written up in an AP article a couple of days ago, I believe, goes to the heart of what this is about today.

The serious shortfall of family physicians in at least five States by 2020 is directly related to this kind of reimbursement. I believe it could be said they treat a lot of Medicare patients. They are the ones who, along with the nurses, are the front-line providers of care in many communities in many areas. When we are seeing this kind of shortage, we are only seeing the tip of the iceberg, in my opinion.

So I am very interested to hear the testimony that will be offered. I yield back.

MR. FERGUSON. I am pleased to recognize for an opening statement the gentleman from Texas, the distinguished chairman of the Energy and Commerce Committee, Mr. Barton.

CHAIRMAN BARTON. Thank you, Chairman Deal, although you look strangely like Congressman Ferguson, for holding this important hearing. I want to welcome our numerous witnesses here. I think this is a record for most witnesses on one panel, although we had an O and I hearing downstairs that had almost as many that started this morning.

MR. BURGESS. But they all took the Fifth.

CHAIRMAN BARTON. Yes, they all took the Fifth Amendment against self-incrimination, unfortunately.

This is an important hearing. I think you are going to have an action item result hopefully from this hearing, so it really is important that you all be here.

In July this subcommittee held a number of hearings to examine how we currently pay physicians, what we need to think about when we talk about how to pay physicians, and how to protect the taxpayers from falling prey to the use of unnecessary services.

We heard about rapid growth in physician spending from imaging services. We heard of the many concerns concerning Medicare's payment for those services. We heard about the flaws in the current physician payment system that may contribute to overuse of physician services. We heard about the promise of a system that more fairly pays physicians for the services that they provide, those that reflect the best quality and efficient care that a physician can provide for any particular patient.

I have said this before publicly, and I will say it again at this hearing: Our current payment system for physician reimbursement is broken, it doesn't work. We can't fix it. We can't put another Band-Aid on it like we have been doing. We keep coming back every year to try to provide a one-year override. Because of the way the current system is structured, every year that we do that we just dig the hole deeper for next year. We are spending billions and billions of dollars each year, and we are getting further and further behind. It is time, in my opinion, for real reform and real change.

I want to thank each of you today for coming here to discuss how we can do that, how we can roll up our sleeves in the next few weeks and come together to provide a multiyear--and I want to emphasize that--multiyear payment stabilization plan with some bonuses for those that will work with us to contain growth in spending and advance quality and efficient health care.

I want to reiterate that. I am prepared to repeal the SGR system. I am prepared to put on the table a multiyear approach that holds physicians harmless, at a minimum, and provides some incentives for some additional payments based on what physicians themselves voluntarily do to advance quality and efficient health care.

I don't have the system planned. I want to tell each of you that. We have a concept, but this committee and our staffs are willing to work with the witnesses and the trade groups that are represented before us today to find the solution in the next month or month and a half before we come back for the lame duck after the election. We want to build a better system, one that provides the correct incentives for proper care, instead of the wrong ones, ones that recognize that their savings accrued when chronic care is managed effectively.

I want to assure everyone in this room that I am 100 percent committed to enacting legislation this year. We are not talking about something for next year. We are talking about something for this year.

Again, I am more than willing to support totally scrapping the SGR system and holding doctors harmless for that deficit. I think it is kind of funny money anyway. I don't really believe that it is an accounting mechanism, I think we can wipe that off the books and then start from scratch. But we are going to have to do it, and we are going to have to do it working in a complementary, cooperative way.

Again, my principles are, let us start with a clean sheet of paper, let us take a multiyear approach, let us provide some incentives for better quality care and more efficient use, and then we will go from there.

Thank you, Chairman, for holding this hearing today. I want to thank our witnesses. We are about to have the Ryan White AIDS reauthorization bill on the floor. It passed out of this committee last week, 38-10.

I am supposed to manage the floor time, so I am going to have to go to manage that. As soon as I get that done, I am going to try to dash back over here, so I can at least ask some questions of these panelists. Thank you, and I look forward to hearing the testimony and reading the testimony today.

[Prepared statement of Hon. Joe Barton follows:]

PREPARED STATEMENT OF THE HON. JOE BARTON, CHAIRMAN, COMMITTEE ON ENERGY  
AND COMMERCE

Good afternoon. I want to thank Chairman Deal for holding this hearing, and for his great work as a subcommittee chairman this Congress. I would like to welcome all of our witnesses here today. I look forward to hearing your ideas for legislation that will avert the Medicare physician payment cut for next year and beyond.

In July, this subcommittee held a series of hearings to examine more closely how we currently pay physicians, what we need to think about when we talk about how to pay physicians tomorrow, and how we protect the taxpayer dollar from falling prey to the use of unnecessary services. We heard about rapid growth in physician spending for imaging services and the concerns of many regarding Medicare's payment for those services. We heard about the flaws in the current physician payment system that may contribute to overuse of physician services. We heard about the promise of a system that more fairly pays physicians for the services they provide – those that reflect the best quality and efficient care that a physician can provide for any particular patient.

I said it before and I'll say it again, the current payment system must be broken if we have to keep coming back each and every year to override cuts. Every year we provide some form of payment relief, although arguably we are still not actually paying you for the true cost of your services. Each and every year we are pressured to spend billions, repeat, billions, of taxpayers dollars to do something, and each year it costs even more to do just the minimum.

And for what? Even if we continue with this Band-Aid strategy for treating the physician-payment complaint, the disease will never be cured. We'll be back here next year, and then the next year, peeling off the old Band-Aids and putting on a new ones.

This is just simply not responsible behavior, it is not rational behavior and it is just plain not sustainable.

I want to thank the panelists for coming here today to discuss how we can roll up our sleeves in the next few weeks and come together to provide a multi-year payment stabilization with some bonus for those that work with us to contain growth in spending and advance quality and efficient health care. I'd like to work with you to build a better payment system, one that provides the right incentives for care instead of the wrong ones, and one that recognizes that there are savings accrued when chronic care is managed effectively. I want to assure everyone in this room that I am one hundred percent committed to enacting legislation this year to avoid the impending physician cuts, scheduled to go into place in January.

Thanks again to Chairman Deal for calling this hearing, and to all the witnesses for coming today. I look forward to their testimony. I also look forward to working with them and my colleagues to find a viable, long-term solution to the Medicare physician payment system.

MR. FERGUSON. I am pleased to recognize Mr. Green for an opening statement.

MR. GREEN. Thank you, Mr. Chairman. I would like to ask unanimous consent for all members to be able to place a statement in the record if they couldn't be here during this time.

MR. FERGUSON. Without objection.

MR. GREEN. I want to welcome our panel, although by seeing all your first names is Doctor it reminds me of that movie Spies Like Us a few years ago with Dan Aykroyd and Chevy Chase where everybody was a doctor in his tent and they couldn't get anything done because they were calling each other Doctor so much.

I say that because I have a daughter and son-in-law who are also physicians. But I want to thank the Chairman of the committee, Chairman Deal, and even stand-in Chairman Ferguson now for holding the hearing on the looming cut in physician payments under the Medicare program.

There isn't one of us in this room who hasn't been well educated by our local physicians about the problems of physician fee schedule and the 5.1 percent rate reduction doctors are scheduled to see next year. Every time I meet with a physician group on this issue, I tell them I would like to see a permanent solution to the problem, which comes before us nearly every year and we address with a short-term fix.

I am glad to hear the Chairman, because he has told me many times he would like to see a permanent fix to this. There is no question that the SGR system is fundamentally flawed. While physicians point out that the formula produces updates which are out of line with current practice costs, there are many elements of the SGR that are inconsistent with the goals we have for the Medicare program.

On the individual physician level, the system does not produce the incentives we expect it to. That is, a reduction in the fee schedule on a

nationwide level would not cause physicians to reduce the volume of services in their individual offices.

On the programmatic level, the system does not acknowledge the increasing focus on preventive health care. In fact, the SGR system would seem to discourage the use of preventive services because that would increase volume, despite the logical conclusion that increased volume and cost-effective preventive benefits would reduce the more costly hospitalizations for medicare beneficiaries.

On the beneficiary level, the system does not provide adequate assurances that Medicare remains an affordable option for beneficiaries. Each fix Congress puts in for physicians increases the Part B premium, since beneficiaries pay 25 percent of the total cost.

In the past few years we have seen double digit increases in the Part B premium, which is slated to be \$93.70 a month by 2007. But make no mistake about it, I agree with physicians--that this issue could easily turn into an access problem. I will add, I have a very urban district in Houston, and physicians in my area cannot afford not to have Medicare. But I know what will happen when that physician retires or passes away. There will not be a family practice, that we heard earlier, or someone to take their place. So we will have an access problem even in areas where 40 or 50 percent of the patient load may be Medicare.

But I am just as worried implementing a fix without premium protection for beneficiaries may create a separate access problem, by potentially pricing them out of the program.

That is why I am a cosponsor of a solution promoted and put forward by Ranking Member John Dingell that provides a positive update of 2.7 percent, while also protecting beneficiaries from any premium increases or result in any increased cost in the program as a whole.

The Dingell legislation would give us time to make sure the changes we make strike the right balance between providing physicians with appropriate payments and ensuring that these payments don't have unintended negative consequences on beneficiaries served by the Medicare program.

I appreciate our witnesses today, but it seems like we are here every year. We are talking about a short-term fix, whereas the Chairman wants a full long-term fix, I would hope we could do it in the lame duck, in the few days we will be here, but I would like to at least make sure we send a message to physicians that the 5.1% cut will not go into effect next year. I would love to be able to work on a long-term fix, whether it is in November or January of next year.

I yield back my time.

MR. FERGUSON. Dr. Norwood is recognized for an opening statement.

MR. NORWOOD. Thank you very much, Mr. Chairman. I would like to start by saying to Chairman Deal and Chairman Barton how much we appreciate their efforts in trying to solve this problem. I was delighted to hear what Mr. Barton was telling you. When he says you are going to have legislation, you can pretty near count on it. This has to be done this year.

Unlike Mrs. Capps, I think this is not a total waste of time. I think this is extremely important we have this hearing. You may not understand how vicious the competition is for hearing time. For this subject to have five hearings in the Commerce Committee is a very good thing. That is indication that there are a lot of people sitting up here, know this problem must be fixed, and we have to do it very soon.

I also want to thank Mr. Dingell for his remarks. I think he was right on the money with what he was saying, and that implies to me that there is absolutely no reason that both sides of the aisle here can't work out a solution to this problem, from what I am hearing from the Ranking Member and from the Chairman.

We are finally, and it has taken over a year, focusing on concrete proposals addressing physician payment Medicaid. If we need to focus today, hear you, maybe we could get all 10 doctors--it is not often Commerce Committee gets 10 doctors before them. That is always a good thing. But if you could just go spend about 3 hours over at Ways and Means, that would probably help the Congress a great deal, too.

There may be three committees of jurisdiction over this issue, but in my mind, and I am certain, too, in Mr. Dingell's mind, this is the committee that needs to take the lead, and this is the committee that needs to solve this problem. We have all shared our thoughts in past hearings. Admittedly, I probably shared more than my 2 cents worth, but this is an issue that I know how important it is, you know how important it is, and it has got to be addressed. It is not going to be easy. You can't find a solution with this without understanding where the money comes from.

You can't just simply say, go spend it. For us, we have to find offsets. That is hard. That means it has to come from somebody else. As I told Chairman Deal, so what if it is hard. This is a top priority that should be fixed, and it is monies that has to come from somewhere. Let us buckle it up and get it done, figure out where it is coming from. Frankly, nothing in health care is easy in this town if you do it right.

Dr. Burgess and I have H.R. 5866, which I like. It is not a temporary fix, it is a long-term fix. We honest-to-Pete look for offsets trying to find where this money would come from. I think my friend John Dingell will agree that HMOs need to cough up some.



Dr. Burgess' bill replaces the SGR and updates the program. I am glad the Chairman's proposal incorporates some of our ideas, that is great, by further utilizing quality improvement organizations to help doctors adapt to health IT. I have long supported QIOs and hope we will also be able to modernize them under this bill.

Generally speaking, I support Chairman Barton's effort to enact a multiyear fix. I am happy, I think, Mr. Dingell and Chairman Barton can work this out so everybody can support it.

I want to see, however, a permanent solution, but we will have a very short time left, as you know. I will suggest this. Maybe we shorten this plan to the next 2 years and give our doctors a guaranteed 1 percent raise instead of a half a percent raise. I know it isn't enough, but maybe it would keep a few more doctors in the programs for a couple of years.

You give us more than a year of guaranteed updates and Dr. Burgess and myself and others will sit down and develop a very real long-term solution. I am not going to sit on my hands on this and I know neither is my friend right next to me. Neither is, by the way, our friend from Georgia who is not on our committee, Dr. Price, from Georgia, who is here today. I thank you for attending. I like the idea of HHS reporting on a long-term replacement to the SGR.

Maybe we should insert a provision, however, that says doctors get another percent every time it takes HHS to solve the problem. We need to give them some incentives, too. I will be happy to write language to cut a few bureaucrat paychecks to make sure seniors in my district keep their doctor.

That includes me, too, Mr. Chairman. I am a new Medicare recipient. A new survey found that 19 percent of the doctors in Georgia said they stopped accepting new Medicare patients last year. That is true. That did happen, is happening. Twenty-six percent are out there telling us they will stop accepting new patients next year if this cut goes through. I am also for avoiding mandatory reporting or mandatory pay-for-performance, which I hope you will think very long and hard about, could be very short-sighted and could be an absolute recipe for disaster down the road, considering who CMS is.

The proposal before us ensures that any reporting is not tied to penalties. That is good, because it would be, for me, a nonstarter. I wish I could tell the providers out there we could get something to the floor this week, I would love it. But I am sorry, I don't think that is going to happen, but you heard my Chairman, and he doesn't tell a story. He is committed to get this thing done before Christmas, and it is all right with me if it is Christmas Eve, if that is what it takes, but we will try to get this done for you this year.

With that, I yield back, Mr. Chairman.

MR. FERGUSON. Dr. Burgess is recognized for an opening statement.

MR. BURGESS. Thank you, Mr. Chairman, I will be brief, because I have stated my feelings on this subject many times in hearings during this summer and the past several months, and I am anxious to hear from our panelists, many who have come from a long ways away.

But this hearing, today, is probably our best messaging apparatus to convey to the physician community those who have been visiting us up on the Hill this week and last week and the week before that, really, literally, all year long, and let them know that we are listening, that we understand the magnitude of the scheduled Medicare cuts, and we are working to develop a sustainable solution.

Alan Greenspan, in one of the last meetings I saw him talk, was kind of doing a victory lap around the Hill right before he left, and he addressed a group of us saying Medicare, Social Security, they will bankrupt the country. He said, yes, I am concerned about what those are going to cost.

But let me tell you what I am more concerned about. I am more concerned about whether or not there will be anyone there to provide the services that people want. I don't know that he was talking about doctors that morning, but it certainly struck me that he is talking about physicians my age who are no longer accepting new Medicare patients, no longer treating Medicare patients, are limiting the procedures that they provide for Medicare patients, because I hear it from every community in my district, Doctor, how come I turned 65 and I had to change doctors.

With the 5.1 percent cut in Part B schedule rate to take place in January, access to care will become a greater issue. It is simple economics that physicians and small business owners cannot consistently spend more on care than they earn. The old saying goes, if you are losing a little bit on every patient, don't try to make it up in volume.

Over a span of 9 years physicians face annual costs averaging 5 percent a year, it is foolhardy to think that anyone who has the educational background of a physician, which means they are marginal in their business sense, but still even a marginal business person is not going to be able to continue under that venue.

Dr. Norwood, I thank you for your leadership on this over the years, the years before I got here, and certainly, I thank you for your help with 5866. It is too bad we didn't have more people sign on that. It certainly would have increased my stature with the Speaker. It might not have helped your problem but would have made life better for me.

I encourage my friends on the other side of the aisle. I don't know what you have been told, but please look at this legislation. It is good legislation, and even if we are not getting something done before

Saturday at midnight, it sends a message to whoever is in leadership next year that every Member of this Congress wants this fixed, and they want it fixed in a sustainable way that doesn't just keep making the problem worse.

I also share with Dr. Norwood his commitment to not tying increases in compensation to reporting. I think voluntary reporting is the way to go, and I am concerned not just that doctors haven't kept pace and that punitive reporting will drive, will have the perverse effect of driving more doctors out of Medicare, but I am also concerned about driving an additional wedge in the health care disparities we already have in this country.

What young doctor in their right mind will go to a community where health literacy is low if they are going to be penalized by their quality reporting when they could bring it back to CMS.

I could extend a special welcome to literally everyone on the panel. I know I have spoken to most of you, if not once, at least many times over my short tenure here in Congress. But since my brother is a pathologist, let me acknowledge Dr. Cook, who is with us, specializing in blood banking and serves as both the President of the American Health Quality Association and the Chief Medical Officer of the Virginia Health Quality Center.

She and her staff have been invaluable working with my staff to develop language that would improve QIO function and accountability. I think the QIOs represent a vital component and an integral part of the reforms that we are going to discuss here today.

Mr. Chairman, I apologize, I used all my time. I will yield back 30 seconds.

MR. DEAL. [Presiding.] I thank the gentleman. Mr. Shimkus, you are recognized for an opening statement.

MR. SHIMKUS. I am just glad Dr. Burgess was brief, and I will yield back my time so I can hear the panel.

MR. DEAL. Mr. Shadegg, you are recognized for an opening statement.

MR. SHADEGG. I am going to try to be brief. I won't be as brief as Mr. Shimkus, but I will try to be shorter than my friend, Dr. Burgess. I commend him and my friend, Dr. Norwood.

I think my views on this are well-known. I believe the current system is broken, I believe it is fundamentally flawed in design. I think it needs to be corrected. I think it is absurd to tell doctors in America you are expected to perform these services, but we are going to give you cut after cut after cut.

My view on that issue is that it is fundamentally dishonest for politicians to promise benefits and then not pay the price tag to pay for

those benefits. I may not be a doctor, but I have those strong views, and I will continue to fight for them.

The only way we can handle this issue fairly is either pay for the services that we have promised or, if we can't afford those and can't find the money, as Dr. Norwood said elsewhere as promised, then cut back on what you promised, because running a system on the backs of the providers is fundamentally unfair. It is deceitful to the American public, and it is simply a practice that we cannot continue to tolerate.

I do want to, in my brief remarks, echo what Dr. Norwood say about pay-for-performance. I wholeheartedly believe in pay-for-performance, but that is performance judged by the consumer, not performance judged by the government. I understand that the intentions of those who think that pay-for-performance is a good idea may be very solid and very sound.

But the government will never be able to accurately measure the performance of physicians or hospitals. At the end of the day, people need to be able to walk with their feet when they have a doctor who is not performing. They need to be able to get away from that doctor when they have a hospital that isn't performing, they need to be able to leave that hospital and send the message.

I have introduced a number of bills in my career in Congress to give consumers choice in the health care market. Let them pick the doctor they want. Let them pick the hospital they want, and you will see quality go up. Is it wrong for the government to try to look at performance? No. But to say we are going to pay for performance, meaning doctors get rewarded for meeting a government set standard, I believe perverts the system. It is not the way the market works.

I do not believe it will function well. I think Dr. Norwood and I share the same view on that issue. So, with that, I will shut up and let these learned scholars inform us of what we can do next. I join Dr. Norwood in saying I hope we can do it soon.

With that, I yield back.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF THE HON. TOM ALLEN, A REPRESENTATIVE IN CONGRESS FROM  
THE STATE OF MAINE

Thank you, Mr. Chairman for convening this hearing to examine the Medicare physician payment system and the effect of future reductions of the Medicare payment rate on patients' access to care.

This Subcommittee has convened four hearings on this subject in the past twelve months, and it doesn't appear that we are any closer to a solution.

We cannot stand by and do nothing about the scheduled 5.1 percent Medicare payment cut to physicians set to begin in January. Unless Congress acts to fix the current reimbursement formula, physicians can expect a 26 percent decline in payments over the

next 6 years. By 2013, Medicare payment rates will be less than half of what they were in 1991 after adjusting for practice cost inflation.

Our failure to act will have a devastating impact on physicians and the patients they serve. A recent survey conducted by the AMA indicates that if the scheduled cuts go into effect on January 1st, 45 percent of doctors will decrease the number of Medicare patients they accept and 40 percent of group practices will be forced to limit the number of new Medicare patients they can accept.

Although physicians across the country are experiencing the impact of low Medicaid reimbursement and rising practice costs, Maine physicians face challenges unique to a relatively poor, rural state. Maine has the highest per capita number of residents enrolled in Medicaid, and our Medicaid reimbursements are among the lowest in the country.

Insufficient payment, by both Medicaid and Medicare, hurts rural states like Maine particularly hard, because they have a disproportionate share of elderly citizens and patients have limited access to physicians, particularly specialists.

Failure to fix the current system will reduce our capacity to train physicians and keep them in the U.S. We are already seeing a decline in medical school applications. Residency programs are relying more and more on foreign medical graduates.

Time is running out, and Congress needs to act now to avert the 2007 physician pay cut by enacting a positive physician payment update that accurately reflects the increases in medical practice costs, as indicated by the Medicare Economic Index (MEI). Over the long-term, Congress must repeal the SGR and replace it with a system that more fully accounts for physicians' practice costs, new technology, and the age and health status of the patient population being served.

PREPARED STATEMENT OF THE HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM  
THE STATE OF MICHIGAN

Mr. Chairman, thank you for convening today's hearing focusing on a draft proposal you've circulated to ensure physicians will have a positive update for the next three years and encourage coordinated, high-quality care. We cannot let things just roll along as they are, continuing to subject physicians to year-to-year uncertainty over whether or not their reimbursement will be significantly reduced and limiting their ability to provide care for their current Medicare patients and accept the onrush of new beneficiaries who will join the rolls as the Baby Boom retires.

Carefully crafted reform is particularly needed to preserving access to care for Michigan's Medicare beneficiaries. With 13.2 physicians per thousand Medicare beneficiaries, Michigan is below the national average, and that ratio is going to get worse. Further, about 33 percent of today's Michigan physicians are over 55 and approaching retirement.

According to a recently released study of Michigan's physician workforce, Michigan will see a shortage of specialists beginning in 2006 and a shortage of 900 physicians overall in 2010, rising to 2,400 in 2015 and 4,500 in 2020. Cuts in Medicare reimbursement will only exacerbate these shortages and seriously undermine access to care in our state.

Since coming to Congress in 1987, one of my top priorities has been strengthening access to health care for all Americans, and particularly for our senior citizens and persons with disabilities. I look forward to working with you and my colleagues on both sides of the aisle to develop a stable, predictable physician reimbursement system that links reimbursement to the true cost of care and the prudent delivery of quality care.

MR. DEAL. I thank the gentleman. I am pleased to have as an observer here today, a gentleman who is a member of my Georgia

delegation. He is not, unfortunately, on our committee but we are pleased to have him here, Dr. Price, and thank you for attending this very important hearing.

It is my pleasure to introduce now--I believe everybody has made an opening statement, have they not--it is my pleasure to introduce our very distinguished panel:

Dr. Dirk Elston, Department of Dermatology at Geisinger Medical Center in Pennsylvania; Dr. William Golden, Chair of the Board of Regents of the American College of Physicians; Dr. Paul A. Martin from Ohio; Dr. Albert W. Morris, Jr., President of the National Medical Association; Dr. Thomas Russell, Executive Director of the American College of Surgeons; Dr. Thomas Weida, Speaker of the American Academy of Family Physicians; Dr. Cecil B. Wilson, Chair, Board of Trustees of the American Medical Association; Dr. Nicholas Wolter, who is the Chief Executive Officer of the Billings Clinic and Director of the American Medical Group Association; Dr. Byron Thames, who is a Board Member of the AARP; and Dr. Sallie S. Cook, President of the American Health Quality Association.

**STATEMENTS OF DR. DIRK M. ELSTON, DEPARTMENT OF DERMATOLOGY, GEISINGER MEDICAL CENTER; DR. WILLIAM GOLDEN, CHAIR, BOARD OF REGENTS, AMERICAN COLLEGE OF PHYSICIANS; DR. PAUL A. MARTIN, PRESIDENT AND CEO, PROVIDENCE MEDICAL GROUP, ON BEHALF OF THE AMERICAN OSTEOPATHIC ASSOCIATION; DR. ALBERT W. MORRIS, JR., PRESIDENT, NATIONAL MEDICAL ASSOCIATION; DR. THOMAS RUSSELL, EXECUTIVE DIRECTOR, AMERICAN COLLEGE OF SURGEONS; DR. THOMAS J. WEIDA, SPEAKER, AMERICAN ACADEMY OF FAMILY PHYSICIANS; DR. CECIL B. WILSON, CHAIR, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION; DR. NICHOLAS WOLTER, CHIEF EXECUTIVE OFFICER, BILLINGS CLINIC, DIRECTOR, AMERICAN MEDICAL GROUP ASSOCIATION; DR. BYRON THAMES, BOARD MEMBER, AARP; AND DR. SALLIE S. COOK, PRESIDENT, AMERICAN HEALTH QUALITY ASSOCIATION, CHIEF MEDICAL OFFICER, VIRGINIA HEALTH QUALITY CENTER**

MR. DEAL. Ladies and gentlemen, we are pleased to have all of you here. Dr. Elston, we will start with you. I would remind everybody that your prepared testimony has been made a part of the record. We would

ask you in your 5 minutes please to summarize it as quickly as you possibly can. Thank you.

DR. ELSTON. Mr. Chairman, members of the subcommittee, thank you for holding this hearing. I am Dirk Elston, Director of the Department of Dermatology at Geisinger Medical Center, the Nation's largest rural health care provider. I am the Academy of Dermatology's representative to the CPT coding panel and the Institute for Quality in Laboratory Medicine, and I cochair the AMA Physician Consortium's Skin Cancer Work Group.

I am here today representing the Alliance of Specialty Medicine and a coalition of 11 medical societies representing nearly 200,000 specialty physicians. We are all aware of the 5.1 percent cut in Medicare reimbursements scheduled to take place next year unless Congress acts this year to prevent the reduction.

At the heart of the problem is the SGR formula. No physician wants to turn away patients, but problems with SGR are forcing physicians to consider their degree of Medicare participation and what degree they can afford. Data presented by the AAMC last year indicate that 40 percent of physicians had to consider and plan to decrease the number of new Medicare patients in their practice, and almost 20 percent say that cuts may force them to reduce the number of established Medicare patients they continue to treat. SGR is jeopardizing access to care for the elderly and the disabled, and we urge Congress to fix SGR once and for all.

Congress is weighing options for adding quality initiatives to the Medicare physician payment system. The Alliance believes that central principles must be upheld. Improved quality should be the primary objective of any initiative so adopted. The program must be voluntary, based on guidelines of care developed by physicians, specialty societies. They must be clinically relevant, continually updated. Quality measures must have widespread acceptance by the physician community before they are implemented, and reporting data must be adjusted for case mix, severity, patient demographics to avoid penalizing physicians who care for sicker patients.

Results must be kept confidential. Physicians must be able to review and correct data errors. To avoid duplication of services, measures must be attributable to the appropriate physician when multiple physicians provide care.

Physicians must not be penalized for volume increases resulting from compliance with performance measures. Reporting should be exempt from HIPAA, and a phase-in period for any such program is the first recommendation of the recent IOM report on the lining incentives in Medicare. Programs must be phased in so that physicians who cannot participate in existing measures are not penalized.

Evaluation of the program would require an initial pay-for-reporting period prior to any pay-for-performance period. Physician participation in any such program requires investment in HIT, and there is an increased burden to physician practices in personnel, education, infrastructure. This is at a time when Medicare reimbursement has not kept pace with the cost of furnishing services.

Incentives must be sufficient to compensate physicians for the disruption in practice and the cost for required resources. Each Alliance organization member is a member of the AMA's physician consortium for performance. The consortium provides an effective forum where all specialties work together to develop measures. Measures must be refined by the full consortium to ensure consensus among the medical societies. We are aware of an effort by CMS to circumvent the development process affected by all development groups.

Changing the process midstream will jeopardize physician trust and acceptance of quality measures. We urge Congress to define the progress of measured development and ensure that if measures go forward, the AMA consortium remains the proponent for the process.

We applaud the leadership of the committee on both sides of the aisle for addressing the serious issue of declining Medicare physician reimbursement. We would like to thank committee Chairman Barton and subcommittee Chairman Deal for soliciting input from physicians and the community.

Regarding the Barton proposal, the Alliance appreciates the menu of reporting options, and the proposal to remove limitations on balanced billing would boost physician payment and make the Medicare program more competitive. Chairman Barton's legislation provides a 3-year positive point 5 update and does not impose penalties on physicians who cannot report quality measures.

The legislation's P-for-P elements are nonpunitive and allow time to ramp up quality reporting with bonus for reporting. In its favor, the Barton proposal would be included as part of law and regulation, beginning the process of digging us out of the payment hole.

We are grateful for all the efforts of Ranking Member Dingell and Congressman Burgess. The proposals outline updates reflecting physician costs under an MEI-based payment system to produce more equitable payment schedule.

We share the same goal, access to high-quality, efficient, patient-centered care. We thank you for your willingness to work with the physician community, and I would be happy to answer any questions.

[The prepared statement of Dr. Elston follows:]



PREPARED STATEMENT OF DR. DIRK M. ELSTON, DEPARTMENT OF DERMATOLOGY,  
GEISINGER MEDICAL CENTER

Mr. Chairman and members of the subcommittee, thank you for holding this hearing on the Medicare physician payment issue. I appreciate the opportunity to present the perspective of medical specialists on legislative proposals pending before the committee, as well as to provide recommendations for modifying the Medicare physician payment formula to ensure continued beneficiary access to timely, quality healthcare. I also thank the committee for its leadership in preventing reimbursement cuts since 2003 and for your continued bipartisan support through proposals to fix the current payment system.

I am Dirk Elston, Director of the Department of Dermatology at Geisinger Medical Center in Danville, Pennsylvania. I co-chair the American Medical Association's (AMA) Physician Consortium's Skin Cancer Work Group. I am a member of the American Academy of Dermatology Association (AADA). I am here today representing the Alliance of Specialty Medicine – a coalition of 11 medical societies, representing nearly 200,000 specialty physicians.

#### **The Un-Sustainable Growth Rate**

As we are well aware, sharp cuts in Medicare physician payments will take effect on January 1, 2007 unless Congress takes action this year to avert this reduction, and keep the program strong for seniors and disabled patients and the physicians who care for them. At the heart of the problem is the Sustainable Growth Rate (SGR) formula which calculates annual updates in Medicare payments for Part B physician services. Under this flawed formula:

- Payments are tied to fluctuations in the Gross National Product (GDP) instead of the costs of furnishing medical care to Medicare patients and running a medical practice;
- Costs for Medicare Part B covered drugs are in the payment formula although drugs are separate and distinct from physician services; and
- Physicians are penalized for increases in the volume of services they provide that are beyond their control – such as new benefits authorized by legislation, regulations, coverage decisions, new technology, growing patient demand for services, and the growing number of beneficiaries.

If the SGR formula is not fixed, physicians will receive negative updates of approximately five percent each year from 2007 until 2015.<sup>1</sup> These reductions may prompt a number of physicians to reconsider their participation in the Medicare program, to limit services to Medicare beneficiaries, or to restrict the number of new Medicare patients they are able to accommodate in their practice.

As advocates for patients and their specialty physicians, the Alliance of Specialty Medicine is very concerned that failure to correct the flaws in the Medicare physician payment system will put the healthcare of seniors and disabled patients in the Medicare program at risk. No physician wants to turn away patients or limit health care to our nation's elderly and disabled patients, but decreasing reimbursement will negatively impact the ability to provide these services. Therefore, for the sake of our patients, the Alliance urges Congress make the prevention of the scheduled 5.1 percent reimbursement cut in 2007, the first order of legislation business when lawmakers return to work in November.

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<sup>1</sup> 2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance. April 2006. Pgs. 135-136.  
<http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2006.pdf>

### **Pay-For-Reporting/Pay-For-Performance**

As Congress seeks methods to incorporate quality incentives into the Medicare physician payment system, the Alliance believes that several crucial principles must be kept in mind to ensure the final result preserves patients' access to specialty care and promotes the stability and security of the Medicare program. If a quality-based payment system is eventually adopted, it should not be implemented in a budget-neutral manner that would penalize some physicians and thereby provide a disincentive for further measurement development. And, physicians must not be penalized for any volume increases resulting from compliance with performance measures as some measures may involve additional office visits or procedures that would only exacerbate the volume calculation in the current SGR formula. Indeed, for these reasons, the Alliance believes that the SGR and pay-for-performance reimbursement systems are incompatible.

A quality incentive system should be phased in over several years. Phasing in should begin with adequate pilot testing and a "pay-for-reporting" period. Any pay-for-performance program should be voluntary and based on evidence-based guidelines of care developed by physicians and physician specialty societies. Quality and safety process and outcome measures used in the Medicare system must have widespread acceptance in the physician community prior to adoption by Medicare.

Over a very short period of time the specialty physician community has come a long way towards the incorporation of quality reporting and performance measures based on these principles. During the past year, every Alliance organization has become a member of the Physician Consortium for Performance Improvement (Physician Consortium) of the AMA. In addition, each Alliance organization has a committee within its individual organizational structure focused on Pay-for-Performance (P4P) or Quality Improvement. Each organization also has mobilized quickly to develop new guidelines of care if they did not exist or work with existing evidence-based clinical guidelines to draft quality measures. However, there are challenges in creating standard quality measures for the diverse medical specialists and sub-specialists that we represent.

### **Measure Development Process**

The Alliance of Specialty Medicine's member organizations have worked diligently to prepare physicians for quality improvement. As members of the AMA Physician Consortium, we understand the current measure development, validation, and implementation processes to include specific steps. In summary, a medical specialty organization proposes quality measures, based on practice guidelines, and the measures are developed and approved by the AMA Physician Consortium. The AMA Physician Consortium process involves private sector insurance companies, state medical societies, organizations geared to ensure quality patient care, methodologists, multiple medical specialty societies, and others to make sure the quality measures are properly vetted. After a public comment period, the AMA Physician Consortium-approved measures are then submitted to a multi-stakeholder group for endorsement. Those endorsed measures are then sent to another multi-stakeholder group that selects a uniform, consistent set of endorsed measures that are warranted for implementation by public and private payers.

It can take up to two years or more for quality measures to go from the initial AMA Physician Consortium submission to implementation. This timeline does not take into account the medical society's own timeline for discussing, developing, testing, and approving the original practice guideline that is the evidence-based foundation for the quality measure. In addition, most of the Alliance member organizations have not been able to participate in Centers for Medicare and Medicaid Services (CMS)'s 16-measure Physician Voluntary Reporting Program (PVRP) because the PVRP measures are not applicable to our specialty physicians. Thus, most Alliance member physicians lack the experience with measurement reporting.

While the measure development process should be fully understood and applied across all organized medicine, as well as scrupulously followed, the process has been vulnerable to misunderstanding. For example, we are aware of an effort by CMS to circumvent the consensus-driven measure development process by requesting that measures go through a multi-stakeholder implementing body before approval by the AMA Physician Consortium. Changing the process midstream will jeopardize physicians' acceptance of the established quality measurement development process currently in place. Furthermore, shifts in the process could lead to the promulgation of measures that do not result in genuine quality gains for patients and physician practices – an outcome that would defeat the purpose of our work to date on measurement development.

Therefore, we urge Congress to ensure that the AMA Physician Consortium remains the proponent for the measure development process. The AMA Physician Consortium has established credibility and plays a critical role in the consensus building process. This process, in which physicians have placed their trust, should not be circumvented. Defining the development process and the AMA Physician Consortium's role in that process is a necessary step before implementing a Medicare Pay-for-Reporting or Pay-for-Performance initiative.

#### **Legislative Proposals**

As mentioned earlier, the Alliance is greatly appreciative of the work of this committee on the Medicare physician payment issue. We would particularly like to thank Committee Chairman Barton and Subcommittee Chairman Deal for soliciting input from the physician community. Chairman Barton's proposal is a step in the right direction for averting the payment crisis over the next three years. We are also grateful for the efforts of Ranking Member Dingell and Congressman Burgess – a physician himself who has interacted with the Medicare program firsthand as a provider.

#### **Chairman Barton's Draft Legislation**

Chairman Barton's draft legislation providing a three-year, positive .5 percent update that does not impose penalties on physicians who do not (or cannot) report quality measures is greatly appreciated by the Alliance of Specialty Medicine. The legislation is consistent with our principles on P4P as it does not contain punitive elements and allows a full year (in 2007) to ramp up to quality reporting in 2008, with a bonus for reporting. In its favor, the positive updates in the Barton proposal would be changes in law and regulation, effectively beginning to dig us out of the SGR payment hole. Thus, the updates will not serve to deepen the scheduled SGR payment cuts in the out years.

Furthermore, the Alliance appreciates the menu of reporting options in the Barton proposal; physicians can report from either the CMS PVRP or from 3-5 structural measures to be determined by the physician community. This is important since, as we have previously stated, because most Alliance member organizations are unable to participate in the PVRP at this time. As members of the AMA Physician Consortium, the Alliance organizations have been engaged in the process of measurement development for the past year. It will take some time for our organizations to work through the process and we greatly appreciate ramp-up period in 2007.

The Alliance would appreciate clarification on how provisions in the Barton proposal that provide for contracts with Medicare quality improvement organizations (QIO) or state medical societies for reporting on utilization would be implemented. Additionally, we are concerned that reporting quality measures will require a good deal of physician practice resources. This may be an increased burden to physician practices in staff time, education, and additional personnel at a time when Medicare physician reimbursement has not kept pace with the cost of furnishing services to beneficiaries. Incentive must be adequate to cover the cost of these resources.

Lastly, removing limitations on balance billing would boost physician payment, while making the Medicare program more competitive. Balance billing, when means-tested as stipulated in the Barton proposal, adds coverage options for beneficiaries, allowing them to compare physician fees and make their decisions accordingly.

**H.R. 5916, the “Patients’ Access to Physicians Act of 2006”**

Ranking Member Dingell’s legislation outlines a positive physician update reflecting physicians’ costs under a Medicare Economic Index (MEI) based payment system for 2007 and 2008, and would produce a much more equitable payment schedule in the short term than is currently in place. Furthermore, the temporary relief provided under the legislation offers lawmakers the necessary time to develop an alternative to the SGR payment formula.

**H.R. 5866, the “Medicare Physician Payment Reform and Quality Improvement Act of 2006”**

As a fellow physician, Congressman Burgess is personally aware that the current SGR payment system inequitably ties updates in Medicare physician payments to fluctuations in the Gross Domestic Product (GDP) and not the costs of health care inputs. Congressman Burgess’s legislation replaces the SGR formula with the MEI minus 1 percent. Cognizance of physicians’ costs under an MEI-based payment system would produce a much more equitable payment schedule.

The Alliance also appreciates the legislative language that any voluntary system of quality measurements that may be established must produce relevant, accurate, and useful data in a manner not unduly burdensome to physicians. H.R. 5866 recognizes that measurement development should take place in conjunction with medical specialty organizations and we strongly agree. It is equally important that new funding be allocated as part of a quality-based Medicare payment system. Attempting to launch such a system under the current constraints of budget neutrality could have the adverse consequence of discouraging quality measurement development and utilization. Further, like the Barton proposal, Dr. Burgess’s legislation also contains a provision for balanced-billing, and we applaud this.

**Conclusion**

The Alliance of Specialty Medicine recognizes the challenges that lawmakers face in creating an equitable Medicare physician payment system that includes quality improvement, and which will lead to genuinely improved quality for Medicare beneficiaries. We applaud the leadership of Chairman Barton, Ranking Member Dingell, Dr. Burgess, and other Republicans and Democrats on this committee for addressing the serious, perennial crisis with declining Medicare physician payments. We sincerely thank you for your willingness to work cooperatively with the physician community. The Alliance is ready to work with the committee to ensure that the Medicare physician payment system is sustainable for the long-term for patients and their specialty physicians, and would ask that this issue be the first order of business when Congress returns from the elections. At this time, I would be happy to answer questions from the subcommittee members. Thank you.

MR. DEAL. Thank you.

Dr. Golden.

DR. GOLDEN. Thank you, Chairman Deal, and members of the subcommittee. Good afternoon. I am William Golden. I am a general internist and a professor of medicine at the University of Arkansas for Medical Sciences. I am also Vice President for Quality Improvement for

the Arkansas Foundation for Medical Care, the State's quality improvement organization; and I serve on the steering committee of the AMA Physicians Consortium for Performance Improvement.

Today, I come to you as Chairman of the Board of Regents of the American College of Physicians, the largest specialty society in the United States with 120,000 internal medicine physicians and medical students. Internal medical physicians see more Medicare patients than any other specialty in this country.

The College urges Congress to enact a plan that stabilizes physician payments in the immediate term while creating building blocks for longer term solutions. A centerpiece should be recognition of the value of care that is managed by a patient's personal physician, using systems of care centered on patients' needs.

We have called this model the patient-centered medical home, and we think it has enormous potential to improve care and achieve cost savings for patients with multiple chronic diseases.

Chairman Barton has developed a discussion draft that incorporates many of these important elements. We also commend Mr. Dingell and Mr. Burgess for introducing bills to eliminate the SGR cuts. I am pleased to share the College's views on each of the key elements addressed in Chairman Barton's proposal.

First, Congress must replace the 2007 SGR cuts with a positive update.

Second, Congress should provide several years of stable, positive and predictable updates as a transition to eliminating the SGR.

This will give physicians the stability needed for them to participate in programs to measure and report their performance. It will also give Congress time to explore important alternatives to the SGR and assess its impact on participation in the program and in demonstration projects.

The College believes that the updates during this transition period are to reflect increases in physician costs and to provide a substantial enough bonus for reporting on quality measures to encourage physician participation. We believe the updates and the discussion draft should be increased accordingly.

Third item, Congress should treat increased expenditures as a change in law and regulation that is included in the Medicare baseline spending. The alternative financing mechanism suggested would treat a positive update as a one-year bonus, would not affect baseline spending, and perhaps result in severe cuts a couple of years out in 2008. For this reason we believe it is preferable to bring the costs of eliminating the SGR down by treating them as higher updates, rather than bonuses.

Fourth, Congress should institute the patient-centered medical home demonstration. There is strong evidence that hospitalization rates for

chronic diseases like diabetes and heart failure can be reduced when care is managed effectively by a personal physician in partnership with patients. We believe that legislation should outline a process for practices to demonstrate that they can provide patients and services supported by HIT, Health Information Technology, and it should direct the Secretary to reimburse appropriate practices, qualified practices for the time and costs associated with this kind of patient centered services.

This should include--could cover time that physicians spent outside the office visit to coordinate care amongst health professionals initiating disease management plans in partnerships with their patients and the use of evidence-based clinical support schools.

It should also give the Secretary authority for cost sharing for patients who received care through a patient-centered Medicare home. We should begin a voluntary, nonpunitive pay-for-reporting program in 2008 with multiple pathways for physicians to participate.

Through my work with the Arkansas Foundation for Medical Care, I know that physicians welcome voluntary programs that provide them with meaningful information and assistance to help them improve quality. But to succeed, they must acquire tools to track their performance and devote time in their practice and with their staffs to collect the information and to apply the information in performance improvement.

Clinical measures should be developed by the multispecialty PCPI to a consensus process endorsed by the NQF and submitted to the AQA for implementation. This kind of uniformity is essential so that physicians are not faced with reporting on different or conflicting measures.

Chairman Barton's discussion draft would also require that physicians participate in utilization management programs, and we believe that this should be one of the options that should qualify for bonus payments rather than being required.

Finally, during the multiyear transition period, Congress should enact legislation to go beyond initial pay-for-reporting and move toward a more robust pay-for-performance program. We believe that it should get prioritized funding for measures that have greatest impact on improving quality and reducing costs, and it should help physicians gain performance payments based on their performance and the efforts they put into reporting.

It should include safeguards against patient deselection based on health status or noncompliance, and such a program could be funded through a separate quality performance pool in addition to the annual updates that reflect increases in costs.

I appreciate the opportunity to share our views and will be pleased to answer questions later.

[The prepared statement of Dr. Golden follows:]

PREPARED STATEMENT OF DR. WILLIAM GOLDEN, CHAIR, BOARD OF REGENTS, AMERICAN  
COLLEGE OF PHYSICIANS

### **SUMMARY**

ACP believes that Congress should embrace the opportunity to pass legislation this year that will transition the dysfunctional Medicare payment policies to a bold new framework that will ultimately improve quality and lower costs by aligning incentives with the need of patients. We believe the elements of this transition should do the following:

1. Replace the 2007 SGR cuts with a positive update for all physicians;
2. Provide a multi-year stable, positive and predictable updates for all physicians;
3. Treat any increased expenditures resulting from such stable and positive updates as a "change in law and regulation" that will be reflected in Medicare baseline spending, reducing the eventual costs of repealing the SGR;
4. Begin a voluntary and non-punitive pay-for-reporting program in 2008, with multiple pathways for physicians to meet the reporting requirements to qualify for a higher (positive) update. This should begin with "high impact" measures that have been approved by the NQF and AQA and that reimburses physicians on a weighted basis related to the number, impact, and commitment of resources associated with the measures being reported;
5. Require the Secretary of Health and Human Services report to Congress on a strategic and implementation plan for eliminating the SGR;
6. Institute a Medicare demonstration of the patient-centered medical home, a new model for organizing, financing, and reimbursing care of patients with chronic diseases that has enormous potential for improving quality and reducing costs; and

Allow physicians to share in system-wide savings in other parts of Medicare that can be attributed to their participation in performance measurement and improvement.

Thank you, Chairman Deal and Ranking Member Brown:

I am William E. Golden, MD, FACP, chair of the Board of Regents of the American College of Physicians. The 120,000 internal medicine physicians and medical student members of the American College of Physicians congratulate Chairman Barton and the members of the House Energy and Commerce Subcommittee on Health for convening today's hearing on "Medicare Physician Payment: 2007 and Beyond."

The American College of Physicians believes that it is essential that Congress take immediate action to reform the dysfunctional Medicare physician payment system. Medicare payments are dysfunctional because they reward high volume, episodic, and fragmented care that undervalues the relationships between physicians and their patient and, as a result, often does not produce desired outcomes. Instead, we need a payment system that is centered on patients' needs, one that recognizes the value of a patient's relationship with their personal physician, and one that provides incentives for physicians to engage in continuous quality improvement and measurement supported by health information technology.

As a general internist in Little Rock, Arkansas and Professor of Medicine and Public Health at the University of Arkansas for Medical Sciences, I have personal experience with the challenges that primary care physicians face in taking care of Medicare patients

under a payment system that systematically undermines and devalues the relationships elderly patients have with their personal physicians.

My perspective on pay-for-reporting is based on decades of experience with quality improvement at both the national and state level. I am vice president for quality improvement for the Arkansas Foundation for Medical Care, the state's Quality Improvement Organization (QIO), and I serve on the Steering Committee for the AMA/Physician Consortium for Performance Improvement (PCPI). I am a former member of the Board of Directors of the National Quality Forum, and a past president of the American Health Quality Association.

#### **Creating a Pathway for Physician Payment Reform**

The College urges Congress to enact a step-by-step plan that stabilizes physician payments in the immediate term, while creating the building blocks for longer term reforms.

Over the past several weeks, the College's Washington staff has had the privilege of working with House Energy and Commerce Committee staff to provide recommendations on immediate and longer-term relief from Medicare cuts while taking important first steps toward creating a better payment system for Medicare patients. I congratulate Chairman Barton and the committee staff for opening discussions on draft legislation.

I also wish to thank Dr. Burgess, who has made an enormous contribution to creating a better payment system by introducing H.R. 5866, the "Medicare Physician Payment Reform and Quality Improvement Act of 2006." The College also appreciates Ranking Member Dingell's commitment to replacing the sustainable growth rate (SGR) and reforming Medicare physician payments, as evidenced by his introduction of H.R. 5916, the "Patients' Access to Physicians Act of 2006." It is encouraging to see that there is broad bipartisan support for halting the pending Medicare cuts and instituting other needed reforms in Medicare payment policies.

Our understanding is that Chairman Barton's discussion draft includes the following key elements:

1. It replaces the 2007 SGR cuts with a positive update for all physicians.
2. It provides three years of stable, positive and predictable updates for all physicians.
3. It treats any increased expenditures resulting from such stable and positive updates as a "change in law and regulation" that will be reflected in Medicare baseline spending, reducing the eventual costs of repealing the SGR.
4. It begins a voluntary and non-punitive pay-for-reporting program in 2008, with multiple pathways for physicians to meet the reporting requirements to qualify for a higher (positive) update.
5. It requires that the Secretary of HHS report to Congress on a strategic and implementation plan for eliminating the SGR.
6. It institutes a Medicare demonstration of the patient-centered medical home, a new model for organizing, financing, and reimbursing care of patients with chronic diseases that has enormous potential for improving quality and reducing costs.

I am pleased to share the College's views on each of these elements.

#### *Providing Positive, Predictable and Stable Updates*

The College believes that it is imperative Congress enact legislation to replace the 5.1 percent SGR cut scheduled to occur on January 1, 2007 with positive updates. Halting the 2007 cut and replacing it with a positive update must be Congress's top



priority, because it will be impossible to move forward on other needed payment reforms in an environment when physicians are facing another deep cut.

To this end, we urge the members of the House Energy and Commerce Committee to work with your colleagues on the House Ways and Means Committee, the House leadership, and your colleagues on the Senate Finance Committee to reach agreement on legislation to halt the 2007 cut and replace it with positive updates. It is understandable that there are different perspectives on the amount of the 2007 update, the mechanisms to pay for it, and subsequent steps to achieve reform of the payment system, but these should not stand in the way of halting the 2007 cuts. If action to halt the cuts and replace them with positive updates is not taken before the House of Representative recesses later this week, then it will be essential that an agreement be reached before Congress returns for a post-election “lame duck” session so that immediate action can be taken at that time.

*The College believes that it is preferable to provide several years of predictable, stable and positive updates for all physicians, as Chairman Barton’s discussion draft would do, rather than providing only one year of relief from the SGR cuts.* By setting the updates in statute for the next three years, the Chairman’s discussion draft will provide physicians with the sense of certainty and financial stability needed for them to begin participating in programs to improve, measure and report their performance.

Three years of positive, predictable and stable updates will also give Congress the time needed to explore alternatives to the SGR and to assess the impact on quality and cost of physician participation in voluntary programs and demonstration projects to improve quality and manage the care of patients with multiple chronic diseases. By comparison, providing only one year of guaranteed positive updates, with no assurance that there will be positive updates in 2008--and with the prospect of deep cuts if the update reverts to the SGR formula--would create great uncertainty in physicians’ minds on whether they can afford to invest in the health information technology and other tools needed to effectively assess, measure and improve on the care provided to Medicare patients.

*As much as the College prefers that Congress stabilize physician payments for several years, we believe that even one year of stable, positive and predictable updates is clearly better than allowing the SGR cut to go into effect.*

Chairman Barton’s discussion draft would provide all physicians with a 0.5 percent update in 2007. In 2008 and 2009, the guaranteed updates will also be 0.5 percent for those physicians who do not report on quality measures, and an additional 0.25 percent bonus payment for physicians who voluntarily select from a menu of specified pathways to report on quality or structural measures or improve care of patients with chronic diseases.

We are appreciative that Chairman Barton wants to assure that all physicians will get positive updates, and we very much agree that pay-for-reporting should result in positive incentives for participation in such programs, not punitive cuts for those who cannot participate. *We encourage the Committee to consider increasing the update to at least 1 percent each year, and to provide a greater reporting incentive—e.g. another 1 or 2 percent—for physicians who voluntarily participate in one or more of the pathways.* Providing updates of only 0.5 percent per year, after five years of updates that have not kept pace with inflation, would still leave many physicians in the precarious position of trying to deliver good care to Medicare patients at a time when reimbursement will continue to fall further and further behind their actual costs.

*The College is also pleased that the positive updates in Chairman Barton’s discussion draft would be considered a change in “law and regulation” and incorporated into calculations of Medicare baseline spending, thereby reducing the costs of repealing the SGR.* Alternative financing mechanisms have been suggested that would treat the positive updates as one year bonuses that would not affect baseline spending, the result of which would be to revert to the cuts that would have resulted from the SGR. For

instance, if a one year bonus in 2007 was not included as baseline spending and payments were to revert to the SGR in 2008, physicians would be facing a combined 10-13 percent cut in 2008 (the equivalent of the 5.1 percent cut in 2007 combined with another SGR cut of five or six percent cut in 2008). For this reason, we believe that it is preferable to bring down the costs of eliminating the SGR, as Chairman Barton proposes, rather than the alternative of treating the higher updates as “bonus” payments not accounted for as Medicare baseline spending.

*Creating Incentives for Performance Measurement and Improvement*

Through my work with the Arkansas Foundation for Medical Care, I have found that physicians welcome voluntary programs that provide them with meaningful and actionable information and assistance to help them improve quality. To succeed in such programs, physicians must acquire tools to assist them in assessing, measuring and improving care and to devote a considerable amount of their own and their staff’s time toward the programs.

Providing a small bonus of only 0.25 percent is unlikely to be sufficient to cover the costs physicians will incur in reporting on the measures. For many physicians in small practices, the benefit of participating in the quality reporting programs will not be worth the substantial increase in their practice expenses and time required.

Congress should also allow sufficient time for physicians to identify the clinical and structural measures that are most applicable to their specialty or patient population and to institute the practice changes needed to report on such measures. Although we believe that many physicians could begin reporting on a core set of structural or clinical measures by the end of 2007, a “ramp up” year would allow for more clinical measures to be developed, validated and implemented and for more physicians to acquire the necessary tools and health information technologies associated with most structural measures.

If Medicare pay-for-reporting begins in 2007, we recommend that it start with a menu of structural or clinical measures that most physicians report on, from which physicians could choose to report on the three to five measures most applicable to their specialty and patient population. The data collection process should be structured in such a way to be time efficient and not overly burdensome on the physician practice.

The College also supports the idea of offering physicians several different options for qualifying for the pay-for-reporting bonuses payments, as Chairman Barton’s discussion draft proposes. We are pleased that physicians would be given the option of reporting on evidence-based clinical measures, or on structural measures that demonstrate they are acquiring the tools and technologies needed to support quality improvement and patient safety.

The College recommends that any legislation to initiate a Medicare pay for reporting program should recognize and support the complementary efforts of the AMA/PCPI the National Quality Forum, and the AQA. The Secretary should be required to use measures that are developed through these processes and should not be permitted to substitute different measures.

Any clinical measures that apply to physicians should be developed by the AMA/PCPI, a multi-specialty consensus process that is making remarkable progress in developing measures for all specialties, having completed work on 150 measures in the past year alone. Once developed by the consortium, they should be submitted to the National Quality Forum for validation based on review of the scientific evidence behind the measure. Finally, the measures should be reviewed by the AQA, a multi-specialty stakeholder organization that works to identify measures for implementation that will be applied consistently and uniformly across different performance improvement programs, regardless of the payer administering the program. Such uniformity is essential so that physicians are not faced with reporting on different and conflicting measures for the same clinical condition for different reporting programs. The AQA also looks at the feasibility

of implementing a measure. For instance, the AQA will consider if it is administratively practical for physicians to collect the data needed to report on a measure.

Structural measures should also be based on evidence that they can contribute to improvements in patient safety and quality improvements in physician offices. Structural measures that are used in private sector pay-for-reporting programs, such as the Physician Practice Connection modules developed by NCQA and used in the Bridges to Excellence programs, should be considered as a starting point for identifying structural measures for the Medicare program.

Chairman Barton's discussion draft would also require that physicians participate in a utilization management program administered by a state or regional QIO or state medical society in order to qualify for the reporting bonus. The College suggests that participation in such a program should be one of the *options* to qualify for the bonus payments—along with reporting on clinical or structural measures or participating in a demonstration project on the patient centered medical home—rather than being required of all physicians in order to qualify for the performance bonus. The legislation should also specify that the program is intended solely to provide physicians with confidential and comparative information on how their utilization compares with their peers, and will not be used for claims audits, denials or public reporting.

#### *HHS Report on Alternatives to the SGR*

Any legislation to provide predictable, positive and stable updates must have as its goal the complete elimination of the SGR.

We understand that the price of repeal is very high, but we believe that the price of maintaining a flawed SRG formula is even higher. If the SGR is maintained, Medicare patients will suffer reduced access, as established physicians are forced to limit how many Medicare patients they will see and medical students and young physicians decide not to enter the two primary care specialties--internal and family medicine--that most Medicare patients rely on for their medical care.

Short of repeal, we believe that legislation should at least create a process that will lead to a recommendation and decision on repeal of the SGR. We are pleased that Chairman Barton's discussion draft requires that the Secretary of HHS provide an implementation and strategic plan repealing the SGR, but urge Congress to act before then and replace it with a system that provides positive, predictable and fair updates to all physicians that reflect increases in practice expenses.

#### *Pilot Program of the Patient-Centered Medical Home*

The College is extremely pleased that Chairman Barton's discussion draft includes a demonstration project on the patient-centered medical home. The premise behind the patient-centered medical home is that patients who have an ongoing relationship with a personal physician, practicing in systems of care centered on patients' needs, will get better care at lower cost.

Under the Chairman's discussion draft, participation in the demonstration project would be one pathway for physicians to qualify for the reporting bonus payments, and qualified practices would also be eligible for a new payment methodology that covers the practice expenses and physician and non-physician work associated with care coordination. The discussion draft outlines a process for practices to qualify for this different reimbursement model based on demonstration that they have the ability to provide patient-centered services for patients with chronic diseases. It also gives the Secretary authority to reduce co-payments or deductibles for Medicare patients who choose to receive care through a patient centered medical home.

We believe that this model has enormous potential to improve quality and lower costs, principally through reduced hospitalizations, for patients with multiple chronic diseases.

The key attributes of the patient-centered medical home, as described in a joint statement of principles from the ACP and the American Academy of Family Physicians, are attached. [See Appendix A]

#### Achieving Long Term Reform

By including the patient-centered medical home in the discussion draft, Chairman Barton is creating the foundation for a long-term reform of Medicare physician payments that recognizes the value of care that is coordinated and managed by a personal physician in partnership with a patient. A recent study published in *Health Affairs* (Thorpe, Kenneth and Howard, David, “*The Rise in Spending Among Medicare Beneficiaries: The Role of Chronic Disease Prevalence and Changes in Treatment Intensity*,” 22 August 2006) concluded that *all* of Medicare’s cost increases in recent years are due to the increased numbers of beneficiaries with multiple chronic diseases. The patient-centered medical home demonstration will create a pathway for developing an entirely new financing and delivery model that can achieve better care for such patients at lower cost.

The pay-for-reporting provisions in Chairman Barton’s discussion draft will also allow Medicare to gain experience with the potential of performance measurement and improvement, linked to financial incentives, to improve outcomes and potentially, achieve cost savings. We recommend, however, that during the three-year transition period envisioned in Chairman Barton’s discussion draft, Congress move toward creating a new system that fundamentally restructures the physician payment system, including providing a means to fund pay-for-performance programs that have the greatest potential to improve quality and reduce costs.

First, the SGR should be replaced by a system that allocates a set portion of Medicare spending towards providing an annual update to physicians based on inflation.

Second, Congress should set aside an additional amount to fund a performance improvement pool. This pool would fund physician-directed programs that have been shown to have the potential to improve care and, potentially, achieve cost savings.

Third, Congress should specify that a portion of savings associated with reductions in spending in other parts of Medicare, which are attributable to quality improvement programs funded out of the physicians’ quality improvement pool, would be redirected back to the pool. Such savings would include: reductions in Part A expenses due to avoidable hospital admissions related to improved care in the ambulatory setting and savings resulting from non-physician Part B expenses (such as reductions in avoidable durable medical equipment expenses or laboratory testing resulting from better management in the ambulatory setting that results in fewer complications).

Fourth, the performance improvement pool should include prioritized funding for pay-for-performance programs that use measures having the greatest potential impact on improving quality and reducing costs. We believe that robust evidence-based clinical measures for chronic disease will have a greater impact on quality and cost rather than simple and basic cross-cutting measures broadly applicable to all physicians.

Fifth, performance-based payments funded out of the pool should pay individual physicians on a weighted basis related to performance:

- ☐ Reporting on high impact measures should receive higher performance payments than lower impact measures;
- ☐ The weighted performance payments should acknowledge that reporting on a larger number of robust quality measures typically will require a greater commitment of time and resources than reporting on one or two basic measures;
- ☐ The weighted performance payments should take into account physician time and practice expenses associated with reporting on such measures; and
- ☐ The weighted performance payments should also provide incentives for physicians who improve their own performance as well as those who meet defined quality thresholds based on the measures;

- The weighted performance payments should allow individual physicians to benefit from reductions in spending in other parts of Medicare attributable to their performance improvement efforts.

Particularly for chronic disease conditions, reporting on measures will require a substantial investment of physician time and resources to implement the technologies needed to coordinate care effectively, to follow-up with patients on self-management plans, to organize care by other health care professionals, and to measure and report on quality. These differences should be recognized in the weighted pay-for-performance payments.

During the transition period, Congress should also enact legislation to make the elements of the patient-centered medical home a permanent part of the Medicare program, rather than limiting it to a demonstration project. This should include enacting a new reimbursement model for patients with chronic diseases that recognizes and supports the value of care managed and coordinated by a personal physician in partnership with the patient.

#### Conclusion

The College commends Chairman Barton and the members of the House Energy and Commerce Subcommittee on Health for holding this important hearing.

We believe that Congress should embrace the opportunity to pass legislation this year that will transition the dysfunctional Medicare payment policies to a bold new framework that will improve quality and lower costs by aligning incentives with the needs of patients. This transition should:

1. Replace the 2007 SGR cuts with a positive update for all physicians;
2. Provide multi-year stable, positive and predictable updates for all physicians;
3. Treat any increased expenditures resulting from such stable and positive updates /as a “change in law and regulation” that will be reflected in Medicare baseline spending, reducing the eventual costs of repealing the SGR;
4. Begin a voluntary and non-punitive pay-for-reporting program in 2008, with multiple pathways for physicians to meet the reporting requirements to qualify for a higher (positive) update. This should begin with “high impact” measures that have been approved by the NQF and AQA and that reimburses physicians on a weighted basis related to the number, impact, and commitment of resources associated with the measures being reported;
5. Require the Secretary of Health and Human Services report to Congress on a strategic and implementation plan for eliminating the SGR;
6. Institute a Medicare demonstration of the patient-centered medical home, a new model for organizing, financing, and reimbursing care of patients with chronic diseases that has enormous potential for improving quality and reducing costs;
7. Allow physicians to share in system-wide savings in other parts of Medicare that can be attributed to their participation in performance measurement and improvement.

## APPENDIX A

AAFP and ACP recently adopted a joint statement of principles that describes the key attributes of a patient-centered medical home:

**Personal physician** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

**Physician- directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

**Whole person orientation** – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life: acute care; chronic care; preventive services; end of life care.

**Care is coordinated and/or integrated** across all domains of the health care system (hospitals, home health agencies, nursing homes, consultants and other components of the complex health care system), facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it.

**Quality and safety** are hallmarks of the medical home:

- Evidence-based medicine and clinical decision-support tools guide decision making;
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement;
- Patients actively participate in decision-making and feedback is sought to ensure patients’ expectations are being met;
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication;
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.

**Enhanced access** to care through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and office staff.

**Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit associated with patient-centered care management;
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources;
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access, such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology;
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face

visit, as described above, should not result in a reduction in the payments for face-to-face visits);

- It should recognize case mix differences in the patient population being treated within the practice;
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting;
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Such payments could be organized around a “global fee” for care management services that encompass the key attributes of the patient-centered medical home.

MR. DEAL. Thank you. Dr. Martin.

DR. MARTIN. Chairman Deal and distinguished members of the committee, I am honored to be here today on behalf of the American Osteopathic Association, the AOA, and the Nation’s 59,000 osteopathic physicians practicing in all specialties and subspecialties of medicine.

The title of today’s hearing accurately reflects the AOA’s outlook on this issue. As noted in the title, we have an immediate problem in 2007 and an ongoing problem after 2007.

Mr. Chairman, the AOA wants to acknowledge and thank you, Chairman Barton, Ranking Member Dingell, Congressman Burgess, and other members of this committee, for proposing legislative solutions aimed at addressing this ongoing issue, either in the short term or in a long-term manner.

We also must thank the staff that has devoted countless hours working with physician organizations on this issue. Your efforts are well appreciated. Reform of the Medicare physician-patient formula, specifically the repeal of sustainable growth rate, the SGR formula, is a top legislative priority for the AOA.

The SGR formula is unpredictable, inequitable and fails to account accurately for physician practice costs. We will continue to advocate for the establishment of a more equitable and predictable payment formula that reflects the annual increases in physician practice costs. The AOA believes that a multifaceted approach is needed.

We support provisions included in the Barton discussion draft, H.R. 5866 introduced by Congressman Burgess, and H.R. 5916, introduced by Ranking Member Dingell. Each of these bills offers valuable policy concepts that contribute to the committee’s efforts. We have factored many of the concepts included in these bills into the following recommendations offered as a framework for the committee’s actions.

The top priority for the AOA is the impending physician payment cuts in 2007.

Congress must act to ensure that the 5.1 percent cut is not implemented, and that all physicians participating in the Medicare program receive a positive update.

We continue to support MEDPAC's recommendation that physicians receive a 2.8 percent increase in 2007, but recognize at the same time the financial burden of this request. However, we do believe that an update for 2007 should be significant, given the fact that physician payments are well below inflation over the past 5 years.

The committee and Congress should consider extending positive updates for 2 to 3 years. By ensuring positive updates over a longer period of time, Congress would restore stability and predictability to the physician payment formula and provide physicians some degree of confidence in the future of the Medicare program and may hold this with respect for reimbursement.

Additionally, multiple years of positive payment updates provides Congress time to focus on long-term solutions and the development of a new Medicare physician payment methodology. However, we do not believe that the length of the payment provision should come at the expense of the amount of the payment update. Quality reporting programs should provide maximum opportunity for participation, be voluntary initially and phased in over a 2- to 3-year period. The AOA supports the menu approach suggested by Chairman Barton rather than a program that requires all physicians to report on a standard set of measures.

The menu of options should include quality measures, structural measures as well as a standard set of measures. Additionally, we encourage the committee to recognize physician participation in an existing data collection and evaluation program operated by public and private entities such as the AOA's clinical assessment program as meeting the participation requirement. The development of quality measures must originate with physicians. We strongly promote the Physician Consortium for Performance Improvement as the most appropriate body for the development of physician quality measures.

Resource management programs should be confidential and end up educating individual physicians, not as a means of forcing physicians to reduce the types of services they offer their patients based upon financial and not medical guidelines.

We agree that physicians should be stewards of the Medicare program. However, we do not believe that physicians should be hesitant to provide the needed services for fear of undue scrutiny aimed at the use of medical resources.

Looking beyond 2007, we agree that Congress should develop a new physician payment formula. This formula should provide annual



payment updates equal to increases in practice costs. Physicians participating in quality improvement programs should be provided additional compensation. Physicians practicing in rural and other underserved communities should be rewarded for their service. The basis for a future payment formula should be aligned closely to all Medicare spending on physician services and move away from the faulty data currently being used for the SGR formula. The new formula should be flexible and capable of capturing changes due to growth in beneficiaries and advances in medical sciences.

I appreciate the opportunity to testify before the committee, and again, the AOA applauds your continued efforts to assist physicians and more importantly their patients.

[The prepared statement of Dr. Martin follows:]

PREPARED STATEMENT OF DR. PAUL A. MARTIN, PRESIDENT AND CEO, PROVIDENCE  
MEDICAL GROUP, ON BEHALF OF AMERICAN OSTEOPATHIC ASSOCIATION

Mr. Chairman, my name is Paul Martin. I am a family physician from Dayton, Ohio and currently serve as the Chief Executive Officer and President of the Providence Medical Group, a 41-member independent physician owned and governed multi-specialty physician group in the greater Dayton metropolitan area. I am honored to be here today on behalf of the American Osteopathic Association (AOA) and the nation's 59,000 osteopathic physicians practicing in all specialties and subspecialties of medicine.

The AOA and our members appreciate the continued efforts of you and the Committee to improve the nation's health care system. You are to be commended for your ongoing efforts to reform the Medicare physician payment formula and improve the quality of care provided by physicians. These are goals that we share.

I want to acknowledge and thank you, Chairman Barton, Ranking Member John Dingell, and Congressman Michael Burgess for proposing legislative solutions aimed at addressing this ongoing issue either in a short-term or long-term manner. The AOA supports these efforts.

**MEDICARE PHYSICIAN PAYMENTS: 2007 AND BEYOND**

Since its inception in 1965, a central tenet of the Medicare program has been the physician-patient relationship. Beneficiaries rely upon their physician for access to all other aspects of the Medicare program. Over the past decade, this relationship has been compromised by dramatic reductions in reimbursements, increased regulatory burdens, and escalating practice costs. Given that the number of Medicare beneficiaries is expected to double to 72 million by 2030, now is the time to establish a stable, predictable, and accurate physician payment formula. Such a formula must:

- Reflect the cost of providing care
- Implement appropriate quality improvement programs that improve the overall health of beneficiaries
- Reflect that a larger percentage of health care is being delivered in ambulatory settings versus hospital settings.

The AOA strongly supports the establishment of a new payment methodology that ensures every physician participating in the Medicare program receives an annual positive update that reflects increases in the costs of providing care to their patients. Moreover, the AOA is committed to ensuring that any new physician payment

methodology reflects the quality of care provided and efforts made to improve the health outcomes of patients. As a result of this commitment, we support the establishment of standards that, once operational, will allow for the reporting and analysis of reliable quality data. Additionally, we support the establishment of a fair and equitable evaluation process that aims to improve the quality of care provided to beneficiaries.

The AOA continues to encourage Congress to take appropriate steps to ensure that all physicians participating in the Medicare program receive positive payment updates for 2007 and subsequent years. In its 2006 March Report to Congress, the Medicare Payment Advisory Commission (MedPAC) stated that payments for physicians in 2007 should be increased 2.8 percent. We strongly support this recommendation. Additionally, since 2001, MedPAC has recommended that the flawed sustainable growth rate (SGR) formula be replaced. Again, the AOA strongly supports MedPAC's recommendation.

It remains our opinion that the current Medicare physician payment formula, especially the sustainable growth rate methodology, is broken and should be replaced with a new formula that reimburses physicians in a more predictable and equitable manner. We recognize that comprehensive reform of the Medicare physician payment formula is both expensive and complicated. However, we believe that the long-term stability of Medicare, the future participation of physicians, and continued access to physician services for beneficiaries are dependent upon such actions.

The AOA believes that a future Medicare physician payment formula should provide annual positive updates that reflect increases in practice costs for all physicians participating in the program. Additionally, while we support the establishment and implementation of "pay-for-reporting" programs, we believe that these programs should be phased-in over a period of two to three years and that physicians choosing to participate in such programs receive bonus payments above the annual payment updates for their participation. Additionally, we do not believe that the current Medicare payment methodology can support the implementation of a quality-reporting or pay-for-performance program.

Finally, we believe that a future Medicare physician payment formula should provide the framework for a more equitable evaluation and distribution of Medicare dollars. Under the current program, various components are isolated from each other, thus preventing a fair and thorough evaluation of overall spending. As Congress and the Centers for Medicare and Medicaid Services (CMS) establish new quality improvement programs, it is imperative that Medicare reflect fairly the increased role of physicians and outpatient services as cost savers, especially to the Part A Trust Fund. Quality improvement programs may increase spending in Part B, but very well could result in savings in Part A or even Part D. These savings should be credited to physicians. We encourage the Committee to pursue this as a means of stabilizing Medicare financially.

#### **109<sup>th</sup> CONGRESS LEGISLATIVE PROPOSALS**

Several bills aimed at providing both short-term and long-term solutions to the Medicare physician payment issue have been introduced in the 109<sup>th</sup> Congress. The AOA supports many of these bills and applauds the continued efforts of several Members of Congress and this Committee to find achievable solutions to this ongoing policy issue. Like most Members of Congress, the AOA believes that the year-to-year approach is not in the best interest of our members, beneficiaries, or the Medicare program. A long-term solution must be found. However, we also recognize that short-term interventions by Congress are essential to preserving physician participation in the program and beneficiary access to care while a permanent solution is debated.

Chairman Barton Discussion Draft

In general, we support the framework outlined in the “Barton Discussion Draft.” Specifically, we support provisions of the draft that provide an immediate payment update for all physicians in 2007 while establishing a structure that provide annual positive updates for all physicians over multiple years, allow for a phased-in quality-reporting program, and provide positive payment incentives above the annual payment update for those physicians choosing to participate in the quality-improvement program. Additionally, we are supportive of including provisions that would allow physicians to balance bill beneficiaries, even if on a limited basis, for services provided.

Under the “Barton Discussion Draft,” all physicians participating in the Medicare program would receive a 0.5 percent update in years 2007, 2008, and 2009. Physicians choosing to participate in both a quality reporting and resource utilization management program would be eligible for an additional 0.25 percent payment bonus.

We encourage the Committee to consider increasing the annual payment update to a level that more closely reflects annual increases in practice costs and to create a greater differential between the annual update and the bonus payments for participation in quality-improvement programs. While we appreciate the intent to establish predictability in physician payments over the next three years, we are concerned that the bill falls short of ensuring that physician reimbursements keep pace with annual increases in physician practice costs. Under the proposal, physician payments would increase 1.5 percent over the next three years, but practice costs likely will increase 7 percent to 8 percent.

The AOA agrees with the quality-reporting framework included in the draft bill. The AOA continues to advocate for a more deliberate and phased-in approach to the establishment of a pay-for-reporting and, ultimately, pay-for-performance program. We also agree that a “menu of options” is both advisable and appropriate. We applaud your intent to provide physicians with a variety of participation opportunities. By providing physicians options, the bill aims to maximize the number of physicians able and willing to participate in quality-improvement programs.

Additionally, the AOA encourages the inclusion of provisions that recognize participation in the AOA’s web-based quality-reporting program, the Clinical Assessment Program (CAP), as meeting the requirement of participation in a quality-improvement program under the proposal. The CAP provides evidence-based measurement sets on eight clinical conditions including diabetes, coronary artery disease, hypertension, women’s health screening, asthma, COPD, childhood immunizations, and low back pain. Data elements collected include both demographic and clinical information. The CAP is designed to collect data from multiple clinical sites and provide information regarding performance to participating physicians or group practices. This allows for the evaluation of care provided at a single practice site in comparison to other similar practice settings around the region, state, or nation.

The CAP is widely acknowledged by health care quality improvement experts and commercial insurers as a valuable tool that enhances quality in ambulatory care settings. The CAP produces valuable data on quality improvement. The AOA looks forward to working with the Committee to explore ways that the CAP may be incorporated into the Barton proposal.

Medicare Physician Payment Reform and Quality Improvement Act of 2006 (H.R. 5866)

The AOA thanks Congressman Burgess for introducing the “Medicare Physician Payment Reform and Quality Improvement Act of 2006” (H.R. 5866). The legislation is consistent with many AOA policies related to Medicare physician payment, quality reporting, and Medicare financing. For these reasons, the AOA is on record as a supporter of H.R. 5866.

H.R. 5866 eliminates the sustainable growth rate (SGR) and replaces it with a payment methodology that uses the Medicare Economic Index (MEI) for the purposes of

the single conversion factor beginning in 2007. The provision requires that the single conversion factor shall be the percentage increase in the MEI minus 1 percentage point. This provision meets the AOA's policy objective of eliminating continued use of the SGR formula. The AOA does have concerns about including, in statute, a mandatory reduction in the MEI. We believe that all physicians should receive annual increases that reflect increases in costs, which we believe the MEI accomplishes. We recognize that Congressman Burgess and many Members of the Committee share this goal, but fiscal realities may make the adoption of a full MEI update impractical. The AOA looks forward to working with the Committee to ensure that the deduction of one percentage point in the MEI is eliminated at the earliest possible time following enactment.

The bill also establishes a voluntary quality reporting program for physicians, beginning in 2009. The AOA supports the phased-in approach used by H.R. 5866. We also are supportive of provisions that require quality measures used in the program to be developed by physician organizations and verified by a consensus organization.

Additionally, we strongly support provisions in H.R. 5866 that require the Secretary of Health and Human Services (HHS) to study the financial relationship of the independent components of the Medicare program and authorize balanced billing for physicians. It is important for Congress to consider changes in the Medicare funding formulas that allow for spending adjustments based upon the financial health of the entire program. As Congress and CMS establish new quality improvement programs, it is imperative that Medicare reflects fairly the increased role of physicians and outpatient services as potential cost savers to the Part A Trust Fund. Quality improvement programs may increase spending in Part B, but very well could result in savings in Part A or even Part D. These savings should be credited to physicians. We appreciate Congressman Burgess for including this important study in his bill.

#### Patients' Access to Physician Services Act of 2006 (H.R. 5916)

The AOA thanks Ranking Member John Dingell for introducing the "Patients' Access to Physicians Act of 2006" (H.R. 5916). By ensuring positive payment updates for all physicians in 2007, the bill is consistent with AOA policies. For this reason, the AOA is on record as a supporter of H.R. 5916.

H.R. 5916 closely follows the recommendations put forth by MedPAC. H.R. 5916 would require that the annual update to the single conversion factor not be less than MEI plus 1 percentage point in 2007 and 2008. If enacted, our understanding is that H.R. 5916 would provide physicians with an approximate 2.8 percent update in both years.

The physician payment methodology in H.R. 5916 is supported strongly by the AOA. We recognize that the bill contains other provisions, which may or may not influence the cost of the legislation. The AOA does not have policies on these provisions.

#### **A NEW PAYMENT METHODOLOGY FOR PHYSICIANS—THE SERVICE CATEGORY GROWTH RATE (SCGR)**

The AOA worked with the American College of Surgeons (ACS) to develop a payment methodology that would provide positive annual updates to physicians based upon increases in practice costs, while being conducive to quality improvement and pay-for-performance programs.

The AOA and ACS propose replacing the universal volume target of the current sustainable growth rate (SGR) with a new system, known as the service category growth rate (SCGR), that recognizes the unique nature of different physician services by setting targets for six distinct service categories of physician services. The service categories, which are based on the Berenson-Eggers type-of-service definitions already used by CMS, are: evaluation and management (E&M) services; major procedures (includes those with 10 or 90 day global service periods) and related anesthesia services; minor

procedures and all other services, including anesthesia services not paid under physician fee schedule; imaging services and diagnostic tests; diagnostic laboratory tests; and physician-administered Part B drugs, biologicals, and radiopharmaceuticals.

The SCGR target would be based on the current SGR factors (trends in physician spending, beneficiary enrollment, law and regulations), except that the gross domestic product (GDP) would be eliminated from the formula and be replaced with a statutorily set percentage point growth allowance for each service category. To accommodate already anticipated growth in chronic and preventive services, we estimate that E&M services would require a growth allowance about twice as large as the other service categories (between 4-5 percent for E&M as opposed to 2-3 percent for other services). Like the SGR, spending calculations under the SCGR system would be cumulative. However, the Secretary would be allowed to make adjustments to the targets as needed to reflect the impact of major technological changes.

Like the current SGR system, the annual update for a service category would be the Medicare medical economic index (MEI) plus the adjustment factor. But, in no case could the final update vary from the MEI by more or less than 3 percentage points; nor could the update in any year be less than zero. The formula allows for up to one percentage point of the conversion factor for any service category to be set aside for pay-for-performance incentive payments.

Like the SGR, the SCGR would retain a mechanism for restraining growth in spending for physician services. It recognizes the wide range of services that physicians provide to their patients. Unlike the current universal target in the SGR, which penalizes those services with low volume growth at the expense of high volume growth services, the SCGR would provide greater accountability within the Medicare physician payment system by basing reimbursement calculations on targets that are based on a comparison of like services and providing a mechanism to examine those services with high rates of growth. Reimbursement for low growth services would not be forced to subsidize these higher growth services. By recognizing the unique nature of different physician services, the SCGR would enable Medicare to more easily study the volume growth in different physician services and determine whether or not volume growth is appropriate.

Additionally, the AOA believes the SCGR would provide a sound framework for starting a basic value-based purchasing system. Given the diversity of physician services provided to patients, it is difficult to find a set of common performance measures applicable to all physicians. However, development of common performance measures is much easier when comparing similar services.

#### **CLINICAL ASSESSMENT PROGRAM (CAP)—A MODEL FOR QUALITY-REPORTING**

In 2000, building on the hypothesis that some barriers to transforming evidence into practice may begin during physician post-graduate training and that measurement is key to identifying opportunities for incorporation of evidence-based measures into practice, the AOA launched the web-based Clinical Assessment Program (CAP). The goal of the CAP is to improve patient outcomes by providing valid and reliable assessments of current clinical practices and process sharing of best practices in care delivery.

The CAP provides evidence-based measurement sets on eight clinical conditions including diabetes, coronary artery disease, hypertension, women's health screening, asthma, COPD, childhood immunizations, and low back pain. Data elements collected by the residency training programs include both demographic and clinical information. CAP has been widely acknowledged as a tool to improve quality in ambulatory care and is beginning to provide data on quality improvement. For example, the percent of diabetics having foot exams performed routinely increased 24% in programs re-measuring as of June 2006. Likewise, in outcome of care measures, the LDL cholesterol levels and diabetic HgbA1c have decreased.

The CAP collects data from multiple clinical programs and provides information regarding performance back to participating residency programs. This allows for evaluation of care provided at a single practice site in comparison to other similar practice settings around the region, state, or nation.

The CAP initially measured the quality of care in clinical practice in osteopathic residency programs. In December 2005, the CAP became available for physician offices offering initial measurement sets on diabetes, coronary artery disease, and women's health screening. The "CAP for Physicians" measures current clinical practices in the physician office and compares the physician's outcome measures to their peers and national measures. The AOA looks forward to working with Congress and CMS to explore ways that the CAP may be incorporated into broader quality reporting and quality measurement systems.

### **QUALITY IMPROVEMENT AND PAY FOR PERFORMANCE**

Today's health care consumers—including Medicare beneficiaries—demand the highest quality of care per health care dollar spent. The AOA recognizes that quality improvement in the Medicare program is an important and worthy objective. For over 130 years osteopathic physicians have strived to provide the highest quality care to their millions of patients. Through those years, standards of care and medical practice evolved and changed. Physicians changed their practice patterns to reflect new information, new data, and new technologies.

As a physician organization, we are committed to ensuring that all patients receive the appropriate health care based upon their medical condition and the latest research information and technology. The AOA recognized early on the need for quality improvement and the national trend toward quality improvement programs. In response, we took steps to ensure that our members were prepared for these new programs.

#### **Measure Development, Verification, and Adoption**

The AOA believes that physicians, on a specialty-by-specialty basis, should develop all quality measures that will be used in quality improvement programs—both public and private. The AOA is an active participant in the Physician Consortium for Performance Improvement (Physician Consortium). The Physician Consortium develops measures in a cross-specialty manner that allows for input by all relevant physician specialties, CMS, private insurers, and consumer groups throughout the process. Public and private payers also have an opportunity for input as part of the process. Quality measures developed are subjected to public comment before being sent to the full Physician Consortium for final approval.

The Physician Consortium, in our opinion, should be recognized as the entity charged with the development of physician quality measures under any new program. Additionally, we believe safeguards should be put in place that protect against the undue influence of public agencies or private interest groups who could gain by the adoption of certain standards. However, the AOA does support the ability of appropriate outside groups with acknowledged expertise to already endorse developed standards.

We do not believe that CMS or other Federal agencies should be allowed to implement quality measures unless they were developed by physicians, vetted by the Physicians Consortium, and verified by an independent consensus body. This process, while time consuming, is essential to ensure that the measures are evidence-based and promote positive outcomes for patients. We support the interim adoption of some quality measures, so long as they originate within a physician organization.

#### **Quality-Reporting Principles**

As the national debate on the issues of quality reporting and pay-for-performance began, the AOA established a set of principles to guide our efforts on these important

issues. These principles represent “achievable goals” that assist in the development of quality improvement systems while recognizing and rewarding the skill and cost benefits of physician services.

To support this goal, the AOA adopted the following five principles:

1. Quality-reporting and/or pay-for-performance systems whose primary goal is to improve the health care and health outcomes of the Medicare population must be established. Such programs should not be budget neutral. Appropriate additional resources should support implementation and reward physicians who participate in the programs and demonstrate improvements. The AOA recommends that additional funding be made available through the establishment of bonus-payments.
2. To the extent possible, participation in quality reporting and pay-for-performance programs should be voluntary and phased-in. The AOA acknowledges that failure to participate may decrease eligibility for bonus or incentive-based reimbursements, but feels strongly that physicians must be afforded the opportunity to not participate.
3. Physicians are central to the establishment and development of quality standards. A single set of standards applicable to all physicians is not advisable. Instead, standards should be developed on a specialty-by-specialty basis, applying the appropriate risk adjustments and taking into account patient compliance. Additionally, quality standards should not be established or unnecessarily influenced by public agencies or private special interest groups who could gain by the adoption of certain standards. However, the AOA does support the ability of appropriate outside groups with acknowledged expertise to endorse developed standards that may be used.
4. The exclusive use of claims-based data in quality evaluation is not recommended. Instead, the AOA supports the direct aggregation of clinical data by physicians. Physicians or their designated entity would report this data to the Centers for Medicare and Medicaid Services (CMS) or other payers.
5. Programs must be established that allow physicians to be compensated for providing chronic care management services. Furthermore, the AOA does not support the ability of outside vendors, independent of physicians, to provide such services.

#### Resource Utilization and Physician Profiling Principles

Over the past few years, Congress, MedPAC and other health policy bodies have placed greater emphasis on controlling the use of “resources” by physicians and other health care providers. The AOA supports, in concept, a systemic evaluation of resource use that measures overuse, misuse, and under use of services within the Medicare program.

Additionally, we do not oppose programs that confidentially share with physicians their resource use as compared to other physicians in similar practice settings. However, any effort to evaluate resource use in the Medicare program must not be motivated solely by financial objectives. Instead, the AOA believes that physician utilization programs must be aimed at improving the quality of care provided to our patients. In measuring the performance of physicians, the singular use of utilization measures without evaluation of clinical process and outcomes can lead to adverse impact on care delivery. Tracking methods to determine the unintended consequences of reduced utilization on patient safety should be incorporated in any utilization reports developed.

If the intent of the program is to improve the quality of care, then the validity, reliability, sensitivity, and specificity of information intended for private or public reporting must be very high. Comparative utilization information cannot be attained

through administrative or claims-based data alone without adequate granulation for risk adjustment.

To support the establishment of quality improvement programs that stand to benefit the quality of care provided to patients, the AOA adopted the following ten principles that guide our policy on comparative utilization or physician profiling programs:

1. Comparative utilization or physician profiling should be used only to show conformity with evidence-based guidelines.
2. Comparative utilization or physician profiling data should be disclosed only to the physician involved. If comparative utilization or physician profiling data is made public, assurances must be in place that promise rigorous evaluation of the measures to be used and that only measures deemed sensitive and specific to the care being delivered are used.
3. Physicians should be compared to other physicians with similar practice-mix in the same geographical area. Special consideration must be given to osteopathic physicians whose practices mainly focus on the delivery of osteopathic manipulative treatment (OMT). These physicians should be compared with other osteopathic physicians that provide osteopathic manipulative treatment.
4. Utilization measures within the reports should be clearly defined and developed with broad input to avoid adverse consequences. Where possible, utilization measures should be evidenced-based and thoroughly examined by the relevant physician specialty or professional societies.
5. Efforts to encourage efficient use of resources should not interfere with the delivery of appropriate, evidence-based, patient-centered health care. Furthermore, the program should not impact adversely the physician-patient relationship or unduly intrude upon a physician's medical judgment. Additionally, consideration must be given to the potential overuse of resources as a result of the litigious nature of the health care delivery system.
6. Practicing physicians must be involved in the development of utilization measures and the reporting process. Clear channels of input and feedback for physicians must be established throughout the process regarding the impact and potential flaws within the utilization measures and program.
7. All methodologies, including those used to determine case identification and measure definitions, should be transparent and readily available to physicians.
8. Use of appropriate case selection and exclusion criteria for process measures and appropriate risk adjustment for patient case-mix and inclusion of adjustment for patient compliance/wishes in outcome measures, need to be included in any physician specific reports. To ensure statistically significant inferences, only physicians with an appropriate volume of cases should be evaluated. These factors influence clinical or financial outcomes.
9. The utilization measure constructs should be evaluated on a timely basis to reflect validity, reliability and impact on patient care. In addition, all measures should be reviewed in light of evolving evidence to maintain the clinical relevance of all measures.
10. Osteopathic physicians must be represented on any committee, commission, or advisory panel, duly charged with developing measures or standards to be used in this program.

As quality-reporting, pay-for-performance, and resource utilization programs become more prevalent, fundamental issues must be addressed. Some of our top concerns are:

- Quality and pay-for-performance programs must be developed and implemented in a manner that aims to improve the quality of care provided by all physicians. New formulas must provide financial incentives to those who



meet standards and/or demonstrate improvements in the quality of care provided. The system should not punish some physicians to reward others.

- The use of claims data as the sole basis for performance measurement is a concern. Claims data does not reflect severity of illness, practice-mix, and patient non-compliance. These issues and others are important factors that must be considered. Sole reliance on claims data may not indicate accurately the quality of services being provided. We believe that clinical data is a much more accurate indicator of quality care.
- The financial and regulatory burden quality and pay-for-performance programs will have upon physician practices, especially those in rural communities, must be minimized. Physicians, and medicine in general, have one of the highest paperwork burdens anywhere. We want to ensure that new programs do not add to physicians' already excessive regulatory burden.
- Quality and pay-for-performance programs should have some degree of flexibility. The practice of medicine continuously evolves. Today's physicians have knowledge, resources, and technology that didn't exist a decade ago. This rapid discovery of new medical knowledge and technology will transform the "standards of care" over time. It is imperative that the quality reporting and pay-for-performance system have the infrastructure to be modified as advances are made.

#### **ANALYSIS OF CURRENT MEDICARE PHYSICIAN PAYMENT POLICIES**

In 2002, physician payments were cut by 5.4 percent. Thanks to the leadership of this Committee, Congress averted payment cuts in 2003, 2004, 2005, and 2006 replacing projected cuts of approximately 5 percent per year with increases of 1.6 percent in 2003, 1.5 percent in 2004 and 2005, and a freeze at 2005 levels for 2006.

The AOA and our members appreciate the actions taken over the past four years to avert additional cuts. However, even with these increases, physician payments have fallen further behind medical practice costs. Practice costs increases from 2002 through 2006 were approximately two times the amount of payment increases.

According to CMS, physicians are projected to experience a reimbursement cut of 5.1 percent in 2007 with additional cuts predicted in years 2008 through 2015. Without Congressional intervention, physicians face cuts of greater than 37 percent in their Medicare reimbursements over the next eight years. During this same period, physician practice costs will continue to increase. If the 2007 cut is realized, Medicare physician payment rates will fall 20 percent below the government's conservative measure of inflation in medical practice costs over the past six years. Since many health care programs, such as TRICARE, Medicaid, and private insurers link their payments to Medicare rates, cuts in other systems will compound the impact of the projected Medicare cuts.

Physicians should be reimbursed in a more predictable and equitable manner, similar to other Medicare providers. Physicians are the only Medicare providers subjected to the flawed SGR formula. Since the SGR is tied to flawed methodologies, it routinely produces negative updates based upon economic factors, not the health care needs of beneficiaries. Additionally, the formula has never demonstrated the ability to reflect increases in physicians' costs of providing care. Every Medicare provider, except physicians, receives annual positive updates based upon increases in practice costs. Hospitals and other Medicare providers do not face the possibility of "real dollar" cuts—only adjustments in their rates of increase.

It is important to recognize that, in 2007, substantial changes to other components of the Medicare payment formula will shift billions of dollars which will lead to cuts of up to 10 percent to 12 percent for certain physician services. Congress must act to stabilize the update to the conversion factor in order to bring stability to this volatile system and

dampen the impact of payment cuts caused by unrelated policy changes. The non-SGR related changes to physician payment in 2007 include:

#### Geographic Practice Cost Index (GPCI)

The Medicare Prescription Drug, Modernization and Improvement Act (MMA) (P.L. 108-173) included a three-year floor of 1.0 on all work GPCI adjustments. This provision is set to expire on December 31, 2006. Nationwide, 58 of the 89 physician payment areas have benefited from this provision. If this provision is not extended, many physicians, especially those in rural areas, will experience additional cuts. The AOA supports the “Medicare Rural Health Providers Payment Extension Act.” (H.R. 5118) introduced by Rep. Greg Walden. We urge the Committee to include the provisions of H.R. 5118 in any legislative package considered this year.

#### Five-Year Review

Every five years, CMS is required by law to review all work relative value units (RVU) and make needed adjustments. These adjustments must be made in a budget neutral manner. Changes related to the third five-year review will be implemented on January 1, 2007.

In total, more than \$4 billion will be shifted to E&M codes, which will be increased by upwards of 35 percent in some instances. The AOA supports the changes in values for E&M codes. We believe E&M codes have been undervalued historically. The proposed changes are fair and should be implemented. We do recognize that increases in E&M codes likely will require decreases in other codes as a means to meet statutory budget neutrality requirements. The AOA continues to urge CMS to apply required budget neutrality to the conversion factor versus work RVUs as proposed by the Agency.

#### Practice Expense

CMS also has announced significant changes to the formulas used to determine the practice expense RVU. These changes also are budget neutral and will shift approximately \$4 billion. Again, these increases will require cuts in other areas of the physician fee schedule.

This dramatic shift in the allocation of funding will have a significant impact on many physicians across the country. The AOA is concerned about the impact a reduction in the SGR, along with cuts resulting in the reallocation of funding required by other policy changes, might have upon physicians. While the total impact of the changes will vary by specialty, geographic location, and practice composition; it is clear that physicians in certain specialties may see significant cuts prior to any adjustments to the conversion factor made as a result of the SGR formula. For these reasons, we call upon Congress to ensure that all physicians participating in the Medicare program receive a positive payment update in 2007.

#### Problems with the Sustainable Growth Rate (SGR) Formula

Concerned that the 1992 fee schedule failed to control Medicare spending, five years later Congress again examined physician payments. The “Balanced Budget Act of 1997” (BBA 97) (P.L. 105-33) established a new mechanism, the sustainable growth rate, to cap payments when utilization increases relative to the growth of gross domestic product (Congressional Budget Office, “Impact of the BBA,” June 10, 1999).

This explanation of the SGR not only highlights the objectives of the formula, but also demonstrates the serious flaws that resulted. The AOA would like to focus on three central problems associated with the current formula—physician administered drugs, the

addition of new benefits and coverage decisions, and the economic volatility of the formula.

*Utilization of Physician Services*—The SGR penalizes physicians with lower payments when utilization exceeds the SGR spending target. However, utilization is often beyond the control of the individual physician or physicians as a whole.

Over the past twenty years, public and private payers successfully moved the delivery of health care away from the hospital into physicians' offices. They did so through a shift in payment policies, coverage decisions, and a trend away from acute based care to a more ambulatory based delivery system. This movement continues today. As a result, fewer patients receive care in an inpatient hospital setting. Instead, they rely upon their physicians for more health care services, leading to greater utilization of physician services.

For the past several years, CMS has failed to account for the many policy changes and coverage decisions in the SGR spending targets. With numerous new beneficiary services included in the "Medicare Modernization Act" (MMA) (P.L. 108-173) and an expected growth in the number of national coverage decisions, utilization is certain to increase over the next decade. The Congressional Budget Office (CBO) cites legislative and administrative program expansions as major contributors to the recent increases in Medicare utilization. The other major contributors were increased enrollment and advances in medical technology.

*Physician Administered Drugs*—An additional major contributor to increased utilization of physician services is the inclusion of the costs of physician-administered drugs in the SGR. Because of the rapidly increasing costs of these drugs, their inclusion greatly affects the amount of actual expenditures and reduces payments for physician services.

Over the past few years, you and the Committee encouraged the Administration to remove the cost of physician-administered drugs from the formula. The AOA encourages the Committee to continue pressing the Administration on this issue. We do not believe the definition of physician services included in Section 1848 of Title XVIII includes prescription drugs or biological products. Removal of these costs would ease the economic constraints that face Congress and make reform of the physician payment formula more feasible.

*Gross Domestic Product*—The use of the GDP as a factor in the physician payment formula subjects physicians to the fluctuating national economy. We recognize the important provisions included in the MMA that altered the use of the GDP to a 10-year rolling average versus an annual factor. Again, we appreciate your leadership and insistence that that provision be included in the final legislation.

However, we continue to be concerned that a downturn in the economy will have an adverse impact on the formula. We argue that the health care needs of beneficiaries do not change based upon the economic environment. Physician reimbursements should be based upon the costs of providing health care services to seniors and the disabled, not the ups and downs of the economy.

#### **BENEFICIARY ACCESS TO CARE**

The continued use of the flawed and unstable sustainable growth rate methodology may result in a loss of physician services for millions of Medicare beneficiaries. Osteopathic physicians from across the country have told the AOA that future cuts will hamper their ability to continue providing services to Medicare beneficiaries.

The AOA surveyed its members on July 14-16, 2006 to analyze their reactions to previous and future payment policies. The AOA asked what actions they or their practice

would take if the projected cuts in Medicare physician payments were implemented. The results are concerning. Twenty-one percent said they would stop providing services to Medicare beneficiaries. Twenty-six percent said they would stop accepting new Medicare beneficiaries in their practice and thirty-eight percent said they would limit the number of Medicare beneficiaries accepted in their practice.

Many experts concur with these findings. According to a 2005 survey conducted by MedPAC, 25 percent of Medicare beneficiaries reported that they had some problem finding a primary care physician. MedPAC concluded that Medicare beneficiaries “*may be experiencing more difficulty accessing primary care physicians in recent years and to a greater degree than privately insured individuals.*”

While there are some steps that can be taken by physicians to streamline their business operations, they simply cannot afford to have the gap between costs and reimbursements continue to grow at the current dramatic rate. Many osteopathic physicians practice in solo or small group settings. These small businesses have a difficult time absorbing losses. Eventually, the deficit between costs and reimbursements will be too great and physicians will be forced to limit, if not eliminate, services to Medicare beneficiaries.

Additionally, continued cuts limit the ability of physicians to adopt new technologies, such as electronic health records, into their practices.

### **HEALTH INFORMATION TECHNOLOGY**

A viable interoperable health information system is key to the implementation and success of quality-improvement and performance-based payment methodologies. For these reasons, we support the “Health Information Technology Promotion Act” (H.R. 4157).

Our main focus is ensuring that software and hardware used throughout the healthcare system are interoperable. There is no benefit to be found in the utilization of systems unable to communicate with others. Additionally, the AOA believes strongly that systems developed and implemented must not compromise the essential patient-physician relationship. Medical decisions must remain in the hands of physicians and their patients, independent of third-party intrusion.

The AOA remains concerned about the costs of health information systems for individual physicians, especially those in rural communities. According to a 2005 study published in *Health Affairs*, the average costs of implementing electronic health records was \$44,000 per full-time equivalent provider, with ongoing costs of \$8,500 per provider per year for maintenance of the system. This is not an insignificant investment. With physicians already facing deep reductions in reimbursements, without financial assistance, many physicians will be prohibited from adopting and implementing new technologies.

A July 2006 survey conducted by the AOA demonstrates this concern. According to the survey, 90 percent of osteopathic physicians responding agreed that “decreased reimbursements will hinder their ability to purchase and implement new health information technologies in their practice.” While we continue to advocate for financial assistance for these physicians, we appreciate inclusion of provisions in H.R. 4157 that provide safe harbors allowing hospitals and other health care entities to provide health information hardware, software, and training to physicians. This would, in our opinion, facilitate rapid development of health information systems in many communities.

### **SUMMARY**

Reform of the Medicare physician payment formula, specifically, the repeal of the sustainable growth rate (SGR) formula, is a top legislative priority for the AOA. The SGR formula is unpredictable, inequitable, and fails to account accurately for physician practice costs. We will continue to advocate for the establishment of a more equitable

and predictable payment formula that reflects the annual increases in physicians practice costs.

The AOA believes that a multi-faceted approach is needed to address this issue. We support provisions included in the Barton discussion draft, H.R. 5866, and H.R. 5916. Each of these bills offer valuable ideas that can contribute to the Committees efforts. We have factored many of the concepts included in those bills into the following recommendations offered as a framework for the Committees actions:

1. Congress must act to ensure that all physicians participating in the Medicare program receive a positive update in 2007. We continue to support the MedPAC recommendation that all physicians receive a 2.8 percent increase in 2007, but we recognize that this may be unobtainable. However, we believe that the update for 2007 should be "significant" given the fact that physician payments are well below inflation over the past five years. If the 2007 cut is realized, physician payments under Medicare will fall 20 percent or more below inflation over the past six years. The steady decline in reimbursements and the impact upon physicians and beneficiaries are well documented in our testimony and other reports.
2. Congress should consider extending the 2007 positive payment update for two to three years. By ensuring positive payment updates, Congress would restore some stability in the physician payment formula and provide all physicians some degree of confidence in what the future of the Medicare program may hold with respect to reimbursement. Additionally, multiple years of positive payment updates would provide Congress time to focus on long-term solutions and the development of a new Medicare physician payment methodology.
3. Quality-reporting programs should be voluntary and "phased-in" over a two to three year period.
4. Quality-reporting programs should provide maximum opportunity for participation. The AOA encourages the "menu" approach versus a program that requires all physicians to report on a standard set of measures. This menu of options should include quality measures, structural measures, patient safety measures, and allow physicians to participate in existing data collection and evaluation programs operated by public and private entities.
5. The development of quality measures must originate with physicians. The AOA does not support any program that would allow CMS or other payers to develop and implement quality measures without the direct involvement of physicians. We strongly promote the Physician Consortium for Performance Improvement as the most appropriate body for the development of physician quality measures.
6. Resource management programs should be confidential and aimed at educating individual physicians. The AOA is concerned that resource management programs, if not properly administered, could serve as a means of intimidating physicians into reducing the types of services they offer their patients based upon financial not medical guidelines. We agree that physicians should be stewards of the Medicare program and work to ensure that beneficiaries receive optimal care based upon their medical condition with an eye on the efficient delivery of such care. However, we do not believe that physicians should be hesitant to provide needed services due to undue scrutiny aimed at their use of medical resources.
7. Congress should develop a new physician payment methodology that provides annual increases equal to increases in practice costs. Physicians participating in quality improvement programs should be provided additional compensation. The basis for a future payment formula should be aligned closely to actual Medicare spending on physician services and move away from the faulty data

currently used in the SGR formula. The new formula should be flexible and capable of capturing changes due to growth in beneficiaries and changes in medical sciences.

8. Congress should evaluate Medicare financing as a whole, versus the individual parts. The AOA urges Congress to evaluate the overall financing structure of the Medicare program to determine if increases in Part B as a result of improved access and quality of care delivered results in savings in other parts of the program. We view the elimination of “Medicare funding silos” as a reasonable and obtainable means of financing, partially, a future physician payment formula.

I appreciate the opportunity to testify before the Committee on Energy and Commerce Subcommittee on Health. Again, I applaud your continued efforts to assist physicians and their patients.

MR. DEAL. Dr. Morris you are recognized.

DR. MORRIS. Good afternoon. My name is Albert W. Morris, Jr., and I am a diagnostic radiologist practicing in Memphis, Tennessee. I also serve as the 107<sup>th</sup> President of the National Medical Association. As the Nation’s only organization devoted solely to the needs of African-American physicians and their patients, the National Medical Association serves as the conscience of the medical profession in the ongoing fight to eliminate health disparities in our Nation’s health care delivery system.

The National Medical Association stands in league with our colleagues here today and the entire physician community in calling for the replacement of the current Medicare physician payment formula. The formula is an untenable mechanism that harms physicians and Medicare patients. The National Medical Association embraces efforts designed to improve access to and quality of health care services. Successful efforts will ensure that pay-for-performance increases the quality of health care and decreases health disparities, rather than decreases the quality of health care and increases health disparities.

Our organization is well positioned to provide advice and counsel to Congress and other policymakers on this issue because we have extensive experience in efforts to decrease health disparities. We offer our guidance to you to help develop systems that benefit and do not harm those who are in the greatest danger, the underserved, the underinsured and the uninsured.

In March of this year, our organization hosted its seventh national colloquium on African-American health which addressed evidence-based medicine and pay-for-performance and the projected impact on physician practices. As an outgrowth of the colloquium, we convened a Presidential task force on pay-for-performance that took a serious and in-depth look at the various proposals being advanced in Congress and through the Administration.

Our physician task force members contributed their direct experience with pay-for-performance in various performance-based incentive programs in the States where they practice. Further, the National Medical Association leadership recently launched a grassroots initiative designed to educate and inform our members regarding pay-for-performance. Through these efforts, the National Medical Association developed detailed policy statements and guidance for Congress and policymakers. I will summarize our policy and suggest that you refer to our written testimony for details.

Any proposal for pay-for-performance must ensure that racial and ethnic disparities in health care are decreased, focus on quality, and improve health care outcomes before focusing on cost containment, and be culturally relevant to the populations served. Proposals must give due consideration to stratified measures associated with socioeconomic status, self-reported race, ethnicity, co-morbidities, chronic conditions, high-risk and disease-burdened populations.

Any pay-for-performance proposal must also formally enlist the input of patients and physicians who suffer the ill effects of ethnic and racial health disparities as Congress and others develop, implement and evaluate this process. Further, support must be given to providers in small and solo health care practices to ensure that proper infrastructure for quality data gathering and reporting and implementation of health technology are available.

Therefore, the National Medical Association recommends that quality improvement initiatives targeting minority populations be voluntary, patient-focused and have realistic quality measures. Second, they must be developed and implemented in conjunction with minority physicians. And third, they must recognize the minority physician practice patterns and care dynamics, rewarding those physicians who work with minority patient groups.

We believe following these recommendations will help the Nation successfully achieve its goal of quality, improved health care and efficiency without exacerbating disparities in health care.

Today we are pleased to commend Congressman Michael Burgess of Texas for introducing H.R. 5866. We commend Congressmen Hall, Rogers, Norwood, Whitfield and Sullivan for cosponsoring this legislation.

Dr. Burgess's legislation is an excellent first step in addressing racial disparities because it recognizes the importance of seeking the advice and guidance of physicians who have direct experience and expertise working in underserved areas where patients are often uninsured and suffer greater co-morbidities. We applaud Congressman Burgess for

recognizing the unique needs of minority physicians and those who serve minority populations.

We also thank Chairmen Barton and Deal for their recent efforts to address the Medicaid physician payment problem and hope that they, too, will incorporate Congressman Burgess's language with our other suggestions into any other pending legislation.

The National Medical Association is committed to the highest quality care for all patients and to the optimal delivery of such care under all circumstances. We stand firm in our resolve that pay-for-performance initiatives should not have the unintended consequences of exacerbating racial or ethnic disparities. We look forward to working with you to that end. Thank you, and I will be pleased to answer any questions.

[The prepared statement of Dr. Morris, Jr., follows:]

PREPARED STATEMENT OF DR. ALBERT W. MORRIS, JR., PRESIDENT, NATIONAL MEDICAL ASSOCIATION

#### **Introduction**

On behalf of our physicians and the patients we serve, the National Medical Association (NMA) thanks you for the opportunity to testify before the committee today on the issue of "Medicare Physician Payments." We understand that the hearing will focus on Medicare payments and various proposals for Pay-for-Performance (P4P), or quality measurement.

The (NMA) promotes the collective interests of physicians and patients of African descent. We carry out this mission by serving as the collective voice of physicians of African descent and as a leading force for parity in medicine, elimination of health disparities, and promotion of optimal health.

The NMA is the largest and oldest national organization representing African American physicians and their patients in the United States. The NMA is a 501(c) (3) national professional and scientific organization representing the interests of more than 25,000 African American physicians and the patients they serve. NMA is committed to improving the quality of health among minorities and disadvantaged people through its membership, professional development, community health education, advocacy, research and partnerships with federal and private agencies.

As the nation's only organization devoted to the needs of African American physicians, health professionals and their patients, the NMA serves as the conscience of the medical profession in the ongoing fight to eliminate health disparities in the nation's health care delivery system.

The NMA has historically been an unwavering advocate for health policies that improve the quality and availability of health care of African Americans and other underserved populations. For instance, the National Medical Association was a key force behind such landmark reforms as Medicare and Medicaid. Today, the NMA continues to provide leadership in shaping the national health policy agenda through continued involvement in a variety of critical policy matters.

#### **The Medicare Physician Payment Formula Should be Replaced**

The NMA stands in league with the entire physician community or "House of Medicine" in calling for the replacement of the current Medicare physician payment



formula. The formula, including the so called “sustainable growth rate,” is an untenable mechanism that harms physicians and Medicare patients.

If Congress does not act before the end of 2006, physician payments will be slashed by more than 5% beginning in January 2007. We urge Congress to act quickly to redress this wrong, and ensure that the Medicare payment system is replaced with a fair and more effective system.

#### **NMA’s Views on Pay for Performance/Quality Measurement**

The NMA embraces efforts designed to improve access to and quality of health care services. P4P is of significant interest to the NMA as its implementation will have far reaching effects in communities throughout this country. Successful efforts will ensure that P4P increases the quality of health care and decreases health disparities, instead of decreasing the quality of health care and increasing health disparities.

The NMA is committed to the highest quality care for all patients, and to the optimal delivery of such care under all circumstances. The NMA is focused on the reduction or elimination of all disparities in health care, especially those that are racial and ethnic in origin. As such, we remain committed to the integrity of America’s health care safety net, of which Medicaid and Medicare are vital components.

We stand firm in our resolve that P4P initiatives should not have the unintended consequence of exacerbating racial or ethnic disparities in health care. We also offer our expertise and guidance to Congress and other decision-makers in developing proper programs that benefit, and not harm, those who are in the greatest danger, the underserved and uninsured.

#### **Racial and Ethnic Disparities Are Real and Must Be Corrected, Not Exacerbated by P4P Legislation**

Last week, the Institute of Medicine released a report entitled, “Rewarding Provider Performance: Aligning Incentives in Medicare (Pathways to Quality Health Care Series) (2007).” The NMA was pleased to see that the IOM report encouraged a systematic and phased-in approach to instituting quality measurement and specifically stated:

*“However, pay for performance needs to be closely monitored because it could have unintended adverse consequences, such as decreased access to care, increased disparities in care, or impediments to innovation (emphasis added).”*

Statistics about racial and ethnic disparities should guide Congress, the White House, the Centers for Medicare and Medicaid Services (CMS), the Institute of Medicine (IOM), and other policymakers in their decision-making on P4P.

We urge Congress to review the following statistics about racial and ethnic disparities as they craft P4P or any other quality measurement legislation. For example,

- Racial disparities in health status persist across the entire human lifespan. At the start of life: Black infant mortality is two and a half times higher than that of white babies. And at the end of life: White men outlive black men by 7 years; and white women outlive black women by a half-decade.
- Black Americans lead the nation in 12 of the top 15 leading causes of death, including heart disease, cancer, diabetes, and kidney disease.
- The uninsured have worse health and higher morbidity compared to the insured.
- The uninsured are also more likely to forego needed care and obtain inadequate care for even the most serious illnesses like diabetes, heart disease, hypertension, kidney disease, cancers, and AIDS.
- The uninsured are also less likely to receive preventive services such as screenings for breast, cervical, and colorectal cancer. When they do receive these services, they receive them less frequently than recommended.

- When minorities do have healthcare coverage, there are still deep disparities in healthcare delivery which results in worse health and higher morbidity for minority patients.
- Further, minority patients have poorer health status, higher levels of noncompliance, and greater distrust. Consequently, patient outcomes are significantly influenced by racial disparities in health status, compliance, and overall distrust.
- Well-documented practice patterns among minority physicians are exceptionally well-suited for improving minority care and reducing racial disparities in care.
- As minority doctors are more likely to serve at-risk populations and patients prefer and are more satisfied with racially-concordant physicians, P4P should NOT have the unintended effect of compromising care or access for minority patients by negatively altering provider service patterns (among both minority and non-minority physicians).

*Excellence Centers To Eliminate Ethnic/Racial Disparities (EXCEED). AHRQ Publication No. 01-P021, May 2001. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.ahrq.gov/research/exceed.htm>;*

*Williams, DR. 2003. Racial/Ethnic Disparities in Health, [www.macses.ucsf.edu/News/williams.pdf](http://www.macses.ucsf.edu/News/williams.pdf);*

*2004 U.S. Census*

*The U.S. Department of Health and Human Services, HRSA Health Disparities Collaboratives (HDC) <http://bphc.hrsa.gov/quality/Collaboratives.htm>.*

#### **NMA Experience and Policy on Pay for Performance/Quality Measurement**

##### **NMA Presidential Task Force on Pay for Performance**

As an outgrowth of the NMA's March 2006 7<sup>th</sup> National Colloquium on African American Health entitled "Addressing Evidenced Based Medicine and P4P: Projected Impact on Physician Practices," the NMA convened a "Presidential Task Force on Pay for Performance." The Presidential Task Force took a serious and in-depth look at the various P4P proposals being advanced in Congress and through the Administration. Our physician task force members contributed their direct experience with P4P and various performance-based incentive programs in the states where they practice. Further, the NMA leadership recently launched a grassroots initiative to educate and inform our members about P4P and enlist their advice and guidance on the issue.

The NMA Presidential Task Force found that "responsible governance of P4P" requires the following:

- Quality of care measures must be clearly delineated from cost containment measures.
- All measures must be culturally relevant to the population served, with due consideration to and stratified measures associated with social economic status, self-reported race, ethnicity, co-morbidities, chronic conditions, high risk, and disease burdened populations.
- Quality measures, cost containment measures, and reimbursement formulas must be appropriate for the population served.

- Capacity-building support must be provided to small and disadvantaged health care providers to ensure infrastructure allows quality data gathering and reporting.
- Ample input from a diverse population of specialty and culturally representative physicians and patients should be used in the development, implementation, and evaluation of the effectiveness and impact of P4P measures, policies, procedures, regulations, and programs.
- Effectual physician and patient education on P4P measures, policies, procedures, regulations, and programs must be provided.

Following these recommendations will help the nation successfully achieve its goal of improved quality of care and efficiency in health care cost and systems without exacerbating health care disparities. Without these measures, increased health disparities and health care cost will result, accompanied by a decrease in access to quality care, physician viability, and community economics.

#### **NMA Policy on Pay for Performance**

The NMA has developed written policy on P4P that recognizes that the P4P framework developed and implemented by the Centers for Medicare and Medicaid Services (CMS) is very likely to set the pace for the rest of the nation, given that millions of providers serve the 100 million or so beneficiaries enrolled in Medicare and Medicaid. Accordingly, any P4P frameworks should be constructed with great care, and with the following key considerations in mind:

- Most of the recent experience with P4P has been in large, multi-specialty practices. As many minority physicians practice in the solo or small practice setting, extrapolating results to all practice settings is misguided. More research and analysis of how P4P will impact small and solo practices is therefore warranted and necessary to protect against increased disparities.
- Implementation of health technology would be an important means to effectuate P4P efforts; however, the cost of health technology is often prohibitive for physicians practicing in small or solo practices. According to a recent Commonwealth Fund study, 'Information Technologies: When Will They Make It into Physicians' Black Bags?' -- "There remains a technological divide between physicians depending on their practice environment and mode of compensation. This is a major discrepancy that will need to be addressed since three quarters of U.S. physicians provide care in solo and small group practices.
- The scientific and clinical data that constitute the 'evidence base' by which performance is measured should be compiled across diverse populations. P4P frameworks should therefore focus on 'quality improvement', stratified by appropriate demographic group.
- Clinical data are more reliable predictors of quality improvement than are claims data and therefore P4P frameworks should therefore rely more heavily on clinical data.
- Patients will not necessarily comply with quality improvement protocols just because their health care provider does. In other words – an undesirable clinical outcome does not necessarily bespeak poor [or non-compliant] 'performance' by the provider.
- The design, implementation, and evaluation of P4P frameworks should include practicing physicians with expertise in working among populations that suffer the ill effects of ethnic and racial health disparities.

- P4P frameworks and the current Sustainable Growth Rate [SGR] framework cannot co-exist. SGR must be repealed if P4P is to have any chance of sustained success.
- P4P reporting requirements must be voluntary in this preliminary stage. Requiring cash-strapped providers to report on quality measures while they are still in their infancy further compounds the challenge of systematic data collection.
- Health Information Technology is vital to this process. There must be a national commitment to providing financial and technical assistance to America's healthcare providers, in order to facilitate their transition into the Information Age.

In addition, the NMA supports the American Medical Association's (AMA's) Minority Affairs Consortium Resolution 210, and AMA's Principles for Pay-for-Performance Programs. The resolution is consistent with our position on P4P and a strong statement of AMA's commitment to work with us to eliminate racial and ethnic disparities.

The NMA recognizes that P4P can lead to reduced disparities and improved physician viability, quality of care, and community economics. However, reliable and valid measures must be used; providers must be granted adequate resources to sufficiently develop their infrastructure; and effective 2-way channels of communication must be established allowing physicians and patients necessary input and education on P4P measures, policies, procedures, regulations, and programs.

Therefore, NMA recommends that quality improvement initiatives targeting minority populations must be voluntary, patient-focused, have realistic quality measurements, recognize minority physician practice patterns and care dynamics, reward physicians working with minority patient groups with greater reimbursement for time spent and patient education.

#### **NMA Support for Measures to Address Disparities in P4P Legislation**

The NMA was particularly pleased to see the introduction H.R. 5866, the "Medicare Physician Payment Reform and Quality Improvement Act of 2006" on July 24, 2006. The legislation, introduced by Congressman Burgess and co-sponsored by a number of members of this committee, would address three very important concerns directly related to racial and ethnic disparities.

The Burgess legislation would direct the Secretary of Health and Human Services, to:

- measure quality by "stratified groups and the review of the absolute level of quality provided by a physician or medical group;" and
- include "practicing physicians with expertise in eliminating racial and ethnic disparities in the design, implementation and evaluation of the program."
- Further, the legislation would direct the Secretary to develop quality measures with a consensus building organization that would include those who "serve a disproportionate number of minority patients."

The legislation is an excellent first step in addressing racial disparities because it recognizes the importance of seeking the advice and guidance of physicians who practice in underserved areas where patients are often under or uninsured and suffer greater comorbidities and have direct experience in working to eliminate racial disparities.

We applaud Congressman Burgess for recognizing the unique needs of minority physicians and those who serve minority populations. We hope that this committee and others who are working on P4P follow his wise and thoughtful lead.

We also hope to see legislation and/or regulations that adopt other principles that we have outlined in this testimony. We also thank Chairman Barton and Deal for their recent efforts to address the Medicare physician payment problem and hope that they too will incorporate Congressman Burgess' language, and our other suggestions, into any pending legislation.

Thank you for the opportunity to share the NMA's views with this honorable Committee. The NMA and our leadership look forward to working with you to ensure that any P4P/quality programs are reasoned approaches that seek to eliminate racial disparities.

MR. DEAL. Thank you very much.

Dr. Russell you are recognized.

DR. RUSSELL. Chairman Deal and other distinguished subcommittee members, I am Tom Russell, Executive Director of the American College of Surgeons, and I thank you for the opportunity to testify today on behalf of the 71,000 fellows of the American College of Surgeons.

We are grateful to you for holding this hearing on Medicare physician payments and on the legislation that is needed to build a system that will provide high-quality care for Medicare beneficiaries in the future.

We are grateful to Chairman Barton, Dr. Burgess and Congressman Dingell for drafting bills to stop the 5.1 percent physician payment cut that is scheduled to take place on January 1st, and we owe a special thanks to Melissa Bartlett, who works on Chairman Barton's staff. All three proposals offer a multiyear approach for addressing this issue, and all three would replace the scheduled reduction in the fee schedule conversion factor with at least modest increases in payments.

Given all the other payment policy changes that will be taking effect in 2007, this certainly is the approach we recommend. However, if agreement on a more comprehensive or long-term strategy continues to elude us in the closing days of the 109th Congress, it is vitally important that you at the very least take the steps that are necessary to prevent the 5.1 percent cut on January 1st. This coming year, it will be especially difficult for surgical practices due to a confluence of three factors.

First, due to an increase in payments for certain high-volume services that will occur as a result of the recently completed 5-year review of physician work in the Medicare fee schedule, payments for all but a very few surgical services will be reduced significantly, even if Congress passes legislation to increase the fee schedule conversion factor.

Second, changes are also being implemented in practice expense values listed in the fee schedule both as a result of incorporating new data for some specialties and because of downstream effects of the 5-year review.

Third, facility payments are undergoing changes as a result of the Deficit Reduction Act which cap payments to ambulatory surgical centers at the amounts paid to hospital outpatient departments. Some of the specialties that provide a significant portion of their services to the ambulatory surgery center are among those hit the hardest by the 5-year review and the practice expense changes.

We won't know what the combined impact of all these cuts will be until CMS issues its final rule on the 2007 Medicare fee schedule, but we estimate that some key surgical services will experience net payment decreases of 10 percent or more, even without taking into account the conversion factor reductions being produced by the SGR system.

Finally, it is extremely important to realize that the SGR-related cuts were not due to service volume growth in the major surgical procedures. Surgical service growth rates have on average remained well within the SGR targets for several years so surgeons have been paying the price for volume increases occurring elsewhere in the health care system. For this year, the College of Surgeons has endorsed the concept of establishing a system of separate expenditure targets and conversion factors for various categories of physician services.

The effects of Medicare payment trends are being felt throughout the health care system, and surgical care access issues are becoming more evident. In May, the Institute of Medicine issued a series of reports on the future of emergency care in the United States which noted that many of the Nation's emergency departments and trauma centers are experiencing shortages in the availability of on-call specialists. But the cause of concern is not limited to the emergency setting. A recent report from the Association of American Medical Colleges confirms that the population of surgeons in practice is growing older. The Nation's training system has been producing the same number of surgeons for decades despite a growing and aging patient population. As a result, data on the proportion of active physicians over age 55 show that every surgical specialty is above the national average of 33 percent.

We are growing very concerned that the additional stresses on the financial viability of surgical practices will take us to a breaking point and that many of the surgeons who are near retirement age will finally choose to leave practice altogether.

I would now like to offer several comments on some of the legislative proposals that you are considering. Update for 2007: We believe that final legislative proposals must include an increase in Medicare payments for physicians in 2007 and hopefully in subsequent years. And because past efforts to avoid conversion factor cuts simply postpone the inevitable by pushing the SGR debt off to future years, we believe strongly that any long- or short-term solution must be treated as a

change in law and regulations and thus not contribute to increased spending under the SGR.

**Quality reporting:** While the college agrees that value-based purchasing can improve the quality of care patients receive, there have been many obstacles to surgical participation in Medicare's physician voluntary reporting program. Consequently, we support the concept of a ramp-up year as envisioned by Chairman Barton's draft legislation as well as a menu of quality programs being offered to individual physicians for participation.

Also, I think it is important to point out that the combined efforts of all the medical surgical specialties have been remarkable this past year, and significant progress has been made in the development of physician performance measures. In particular, the multispecialty process that provided by the AMA's physician consortium performance improvement has gained broad acceptance across the profession and will soon produce enough well vetted measures to cover the majority of specialties. It is important for any value-based purchasing program that is created for Medicare to embrace the process of measure development.

**Utilization review:** Two of the legislative proposals place greatest emphasis on educating physicians about their treatment and utilization patterns. We agree this kind of effort should prove very beneficial although caution will be needed in interpreting benchmark reports on individual physicians. The confidentiality, feedback loop and nonpunitive nature of the program are very important, and we are grateful that these requirements have been included in the legislation.

I suspect many of our members would also welcome removal of the statutory limits on balance billing for high-income beneficiaries. However, we do have some practical concerns about this. First, determining the patient's annual income really is not feasible for the typical physician practice. Physicians do not have ready access to this information, and raising income issues directly with patients at the point of care is not conducive to the trusting professional relationship that is so important between a surgeon and his or her patient.

In addition, under current Medicare needs, Medicare sends reimbursement for unassigned claims directly to the beneficiary rather than to the physician. This presents a particularly difficult situation for surgeons. The end result is a significant lag in payment and, in the worst situation, no payment at all.

In conclusion, the college greatly appreciates Congress' actions over the past 4 years to stop the payment cuts being produced by this broken Medicare reimbursement system. But given all the changes coming in 2007, preventing the cuts this coming year is more important than ever. Even with action to prevent the conversion factor reduction in 2007,

some surgical services are likely to experience double digit percentage reduction in medical payments, which is one of the reasons that surgeons support a multiyear approach to addressing the problem.

Mr. Chairman, thank you for providing this opportunity to share with you the challenges facing surgeons under the Medicare program today and to provide specific feedback on the various legislative proposals. Whether the focus is on value-based purchasing or on the sustainable growth rate, the college looks forward to continuing to work with you and other members of your committee to reform the Medicare physician payment system to ensure that Medicare patients will have access to high quality surgical care when they need it.

[The prepared statement of Dr. Russell follows:]

PREPARED STATEMENT OF DR. THOMAS RUSSELL, EXECUTIVE DIRECTOR, AMERICAN  
COLLEGE OF SURGEONS

Chairman Deal, Ranking Member Brown, and distinguished subcommittee members, thank you for the opportunity to testify today on behalf of the 71,000 Fellows of the American College of Surgeons (ACS). My name is Tom Russell and I am the College's Executive Director.

We are grateful to you for holding this hearing on Medicare physician payments, and on the legislation that is needed to build a system to provide high-quality care for Medicare beneficiaries in the future. We are grateful to Chairman Barton, Dr. Burgess, and Ranking Member Dingell for drafting legislation that would stop the 5.1 percent cut in physician reimbursement that is scheduled to take effect on January 1, and we owe special thanks to Melissa Bartlett who works on Chairman Barton's staff.

All three proposals offer a multi-year approach for addressing this issue, and all three would replace the scheduled reduction in the fee schedule conversion factor with at least modest increases in payments. Given all the other payment policy changes that will be taking effect in 2007, this certainly is the approach we recommend. However, if agreement on a more comprehensive or long-term strategy continues to elude us as the 109<sup>th</sup> Congress draws to a close, it is vitally important that Congress takes, *at a minimum*, the steps that are necessary to prevent the 5.1 percent cut on January 1.

While value-based purchasing can improve the overall quality of care that patients receive and allow them to make more informed decisions about their care, more is needed to fix the broken Medicare payment system. The benefits of a value-based purchasing system will not be fully realized until a fair and stable physician payment system is implemented. The College urges Congress to prevent the 5.1 percent payment cut that will go into effect on January 1, and to actively explore long-term solutions to this ever-growing problem.

#### **Unique issues facing surgery**

The coming year will be especially difficult for surgical practices, due to a confluence of three factors:

- **Five-year review.** Every five years, CMS is required by law to comprehensively review all work relative value units (RVUs) in the Medicare physician fee schedule and make any needed adjustments in a budget-neutral manner. This coming year, there will be a significant shift in payments that will increase reimbursement for visit services by over \$4 billion—an amount that exceeds total Medicare spending for services provided by the specialties of



general surgery, neurosurgery, cardiac surgery, and colorectal surgery combined. As a result, *payments for all but a very few surgical services will be reduced significantly even if Congress passes legislation to increase the fee schedule conversion factor.*

- **Practice expense payments.** Changes are also being implemented in practice expense RVUs, both as a result of incorporating new practice cost data for some specialties and because of “downstream” effects of the increase in work RVUs. Practice expense RVUs are determined by a formula that takes into account the amount of work involved in providing each service. As work RVUs increase or decrease following the five-year review, subsequent changes are produced in the practice expense values. Because work values for surgical services overall are falling, the practice expense values for surgery will be reduced, as well.
- **ASC payment changes.** Facility payments are undergoing changes as a result of the Deficit Reduction Act provisions that cap payments to ambulatory surgical centers (ASCs) at the amounts paid under the hospital outpatient prospective payment system. Other regulatory changes planned in 2008 will further impact these payments. For some specialties, a significant portion of their services are provided in ASCs, and many of these facilities are physician-owned. For a specialty like ophthalmology, which is experiencing payment reductions as a result of the five-year review and practice expense changes, the compound effect will be very significant.

Finally, it is important to realize that the conversion factor reductions produced by the sustainable growth rate system (SGR) were not due to increased service volume in major procedures. Surgical service volume growth, on average, has remained well within the SGR target rates. In effect, surgeons have been paying the price for volume increases occurring elsewhere in the healthcare system. It is for this reason that the College has endorsed the concept of establishing a system of separate expenditure targets and conversion factors for various categories of physician services.

#### **Access issues are beginning to emerge**

The effects of Medicare payment trends are being felt throughout the health care system, and surgical care access issues are becoming more evident. In May, the Institute of Medicine issued a series of reports on the *Future of Emergency Care*, which noted that many of the nation’s emergency departments and trauma centers are experiencing shortages in the availability of on-call specialists. Surgeons provide lifesaving care to patients suffering from both traumatic injuries and medical emergencies. Patients suffering from strokes, blockages, and injuries often require timely treatment in order to prevent permanent disability or even death. Without the prompt availability of on-call surgeons, these patients do not receive the services they desperately need.

In an ensuing report entitled *A Growing Crisis in Patient Access to Emergency Surgical Care*, the College documented this problem further. The supply of surgeons has not kept pace with the patient population, a significant number are reaching retirement age, and more are taking advantage of hospital bylaws provisions that allow older surgeons to opt out of emergency call service.

But, the cause for concern is not limited to the emergency setting. A recent report from the Association of American Medical Colleges confirms that the population of surgeons in practice is getting old. The nation’s training system has been producing the same number of surgeons for decades, despite a growing and aging patient population. As a result, data on the proportion of active physicians over age 55 show that every surgical specialty is above the national average of 33.3 percent. In four specialties that

provide significant amounts of care to elderly patients—general surgery, orthopaedic surgery, urology, and thoracic surgery—the number is well over 40 percent.

We are growing very concerned that additional stress on the financial viability of surgical practices will take us to the breaking point, and many of those surgeons who are near retirement age will opt to leave practice altogether. Given the length of time it takes to train a surgeon (averaging six to nine years following medical school, depending on the specialty), any access problems that may result because of early retirements will be difficult to remedy.

### **Legislative proposals**

Rather than individually addressing each of the legislative proposals pending before the committee, I would like to offer comments on various aspects they encompass, most of which are common to all of them.

**Update for 2007.** Surgeons cannot continue to shoulder steep cuts in reimbursement for major procedures. This trend first emerged in the late 1980s, and Medicare payments for many procedures already are half what they were nearly two decades ago, without taking into account the effects of inflation. It is important that any final legislative proposal includes an increase in Medicare reimbursements to all physicians in 2007, and in any subsequent years. And, because past efforts to avoid conversion factor cuts had the effect of simply postponing the inevitable by pushing the sustainable growth rate (SGR) debt to future years, we believe strongly that any long- or short-term solution must be treated as a change in law and regulations and so not contribute to increased spending under the SGR.

**Quality Reporting.** While the College agrees that value-based purchasing can improve the quality of care patients receive, there have been numerous obstacles to surgical participation in Medicare's Physician's Voluntary Reporting Program (PVRP). Consequently, we support the concept of a "ramp up" year as envisioned in Chairman Barton's draft legislation.

Many had hoped that by the end of 2006, enough evidence-based quality measures would have been developed to allow all physicians to participate in a Medicare quality reporting program beginning January 1, 2007. In fact, the combined effort of all the specialties has been remarkable and significant progress has been made. Notably, the multi-specialty process provided by the Physician's Consortium for Performance Improvement has gained broad acceptance across the profession, and will soon produce enough well-vetted measures to cover the majority of specialties, if not yet the majority of physicians. It is important that any value-based purchasing program embrace this process of measure development.

Because of the challenge in developing evidence-based measures that cover all physicians, the College strongly supports Chairman Barton's proposal to allow physicians the option of participating in the PVRP or reporting on three structural measures. We also recommend that legislation include a "hold harmless" provision so that no physician is unfairly penalized if there are no PVRP or structural measures that apply to them.

With respect to the medical home demonstration project in Chairman Barton's draft, we have two concerns. First, we believe the care coordination language should not be limited to chronic conditions. Other conditions and services—notably cancer care—frequently involve the expertise of multiple specialists and extend over long periods of time, although they are not considered "chronic." We would like to see this language expanded to provide authority to CMS to create demonstration projects related to long-term disease management beyond primary care services.

Second, the draft legislation also counts physicians who are participating in the medical home demonstration project as fulfilling the quality reporting requirement. Since the demonstration project involves additional payments for services not currently

reimbursed under Medicare, we question whether it is appropriate to also provide bonus payments for the very same activities. We recommend that the demonstration project be considered a separate component of the legislation and not be treated an option for quality reporting.

**Utilization review.** Two of the legislative proposals would also provide a greater role for the Quality Improvement Organizations (QIOs) and expand their purview to include utilization review. We agree that an educational program that informs surgeons about regional variations in care and that compares their utilization and service volume to others should prove very beneficial. However, it is important to keep in mind that many physicians sub-specialize, and for them physician-specific volume comparisons may be of little value. Practice trends and utilization will also vary by practice settings—a trauma surgeon in a Level I trauma center, for example, will likely provide more critical care services than other general surgeons in the community. Nonetheless, making the data available will no doubt be constructive and provide the basis for close examination at local clinical education sessions.

In addition, the confidentiality, feedback loop, and the non-punitive nature of the program are all very important for physicians to actively participate and we are grateful that these requirements have been included in the legislation.

We have some concern, however, about whether state medical societies typically have the resources needed to coordinate utilization review programs. We would suggest that some consideration be given to allowing national organizations to manage such efforts if they are able to provide state-specific feedback.

**Removing limits on balance billing.** Surgeons have always had the highest rates of participation in the Medicare program. Nonetheless, after decades of cost controls and payment cuts, I suspect many of our members would welcome removal of the statutory limits on balance billing for high-income beneficiaries. We do, however, have some practical concerns with the language included in Dr. Burgess' bill (and that we expect will be included in Chairman Barton's bill).

Determining a patient's annual income really is not feasible for the typical physician practice. Physicians do not have ready access to this information, and raising income issues directly with patients at the point of care is not conducive to the trusting relationship that is so important between a surgeon and his or her patient.

In addition, under current rules Medicare sends reimbursement for unassigned claims directly to the beneficiary rather than to the physician. This presents a particularly difficult situation for surgeons providing major procedures in the hospital setting. Surgical patients do not bring their wallets to the operating room. So, unlike office-based services, it simply is not feasible to ask for payment at the time of service. Instead, a surgeon's bill that is received after discharge must compete for payment with many other—often significantly larger—invoices that the patient receives from other physicians, the hospital, labs, and so forth. The end result is a significant lag in payment and, in the worst situations, no payment at all.

Significant changes would need to be made in the current rules governing balance billing before removing the 115 percent limit could have any meaningful impact on surgical services.

## Conclusion

While the College greatly appreciates Congress' actions over the past four years to prevent the payment cuts, it is more important than ever that action be taken to prevent the 5.1 percent conversion factor reduction that is scheduled to take effect on January 1, 2007. Not only have payments failed to keep pace with the rising cost of caring for Medicare patients in recent years, but other payment policy changes will compound the impact on an aging surgical workforce in 2007. Even with action to prevent the conversion factor reduction in 2007, some surgical services are likely to experience

double-digit percentage reductions in Medicare payments, which is one of the reasons that surgery supports a multi-year approach to addressing the problem.

Mr. Chairman, thank you for providing this opportunity to share with you the challenges facing surgeons under the Medicare program today, and to provide specific feedback on the various legislative proposals. Whether the focus is on value-based purchasing or on the sustainable growth rate, the College looks forward to continuing to work with you to reform the Medicare physician payment system to ensure that Medicare patients will have access to the high-quality surgical care they need.

MR. DEAL. Thank you.

Dr. Weida.

DR. WEIDA. Good afternoon, Chairman Deal, and members of the committee.

I am Dr. Tom Weida, a family physician and Speaker of the Congress of Delegates of the American Academy of Family Physicians. I am pleased to be here to testify on an issue of critical importance to the 94,000 members of the American Academy of Family Physicians and the patients we serve.

AAFP appreciates the committee's commitment to avoid the looming 5.1 payment reduction in the Medicare physician fee schedule for 2007 and to put plans in place to replace the current unsustainable payment system. Under the so-called sustainable growth rate, physicians face steadily declining payments into the foreseeable future, nearly 40 percent over the next 9 years, even while their practice costs continue to increase.

According to the government's own calculations, the Medicare payment rate for physician services has for several years not kept pace with the cost of operating a small business which delivers medical care. Simply put, this formula does not work and must be replaced. But in the short term, the 5.1 percent payment rate decrease for 2007 must be prevented.

The AAFP supports restructuring Medicare payments to reward quality in care coordination. However, restructuring must be built on fundamental reform of the underlying fee-for-service system and a revaluing of physician services, especially primary care.

The academy is committed to working with the committee to help design a new payment system that meets the needs of patients and physicians. While other developed countries have a better balance of primary care doctors and subspecialists, primary care physicians make up less than one-third of the U.S. physician workforce. Compared to those in other developed countries, Americans spend the highest amount per capita on health care but have some of the worst health care outcomes. More than 20 years of evidence shows that having a primary care-based health system has both health and economic benefits. Two years ago, a study comparing the health and economic outcomes of the physician

workforce in the U.S. reached the same conclusion, Health Affairs, April 2004. By not using a system of health care based on primary care physicians coordinating patients' care, the U.S. Medicare system pays a steep price.

What is needed is a system designed to encourage the delivery of the type of care that Medicare beneficiaries need. Finding that more efficient and effective method of compensating physicians for services delivered to Medicare beneficiaries with diverse health conditions is a difficult but necessary task and one that has tremendous implications for millions of patients and for the specialty of family medicine.

From the outset, the Medicare program has based physician payment on a fee-for-service system. This system of nonaligned incentives rewards individual physicians for ordering more tests and performing more procedures. The system lacks incentives for physicians to coordinate the tests, procedures or patient health care generally, including preventive services and care to maintain health. This payment method has resulted in an expensive fragmented Medicare program. Such a payment scheme is outdated and misaligned because it does not adequately compensate physicians who do manage and organize their patients' health care. Currently, there is no compensation to physicians in recognition of the considerable time and effort associated with coordinating health care in a way that is understandable to patients and cost-effective for the Medicare program.

A more aligned payment system would encourage patients to select a personal medical home in which their care is coordinated and expensive duplication of services is eliminated. Such a model, with its emphasis on care coordination, which is advanced by both the AAFP and the American College of Physicians, has been tested in some 39 studies and has repeatedly shown its value especially in patients with multiple chronic conditions which typifies the Medicare population. For example the work of Barbara Starfield, Ed Wagner and others has shown that patients, particularly the elderly who are a usual source of care, are healthier and cost less because they use fewer medical resources than those who do not.

Currently, 82 percent of the Medicare population has at least one chronic condition, and two-thirds have more than one. However, it is the 21 percent of beneficiaries with five or more chronic conditions that accounts for two-thirds of all Medicare spending.

The medical home model is predicated on the fact that most health care for those chronically ill takes place in primary care settings, such as the offices of family physicians. The Institute of Medicine has repeatedly praised the value of and cited the need for care coordination, and while there are a number of possible methods to build this into the

Medicare program, the academy recommends a blended model that combines fee-for-service with a per-beneficiary/per-month stipend for care coordination in addition to meaningful incentives for delivery of high-quality and effective services. Patients should be given incentives to select a personal medical home by reduced out-of-pocket expenses such as copays and deductibles.

The academy also supports efforts to transition to value-based purchasing to improve the quality of patient care. We believe that quality, access and positive health outcomes must be the primary goal of any physician reimbursement system. Prevention, early diagnosis and early treatment will simultaneously improve quality of life and ultimately save valuable health care dollars.

But implementing a system for collection and reporting the necessary data requires an initial investment from the health care provider in the form of electronic information technology. The most recent IOM report on pay-for-performance states that aligning pay incentives with quality improvement goals represents a promising opportunity to encourage higher levels of quality and provide better value for all Americans.

The objective of aligning incentives through pay-for-performance is to create payment incentives that will encourage the most rapid feasible performance improvement by all providers; support innovation and constructive change throughout the health care system; and promote better outcomes of care, especially through coordination of care across provider settings and time. We concur with these recommendations.

It is time to modernize Medicare by recognizing the importance of and appropriately valuing primary care and by embracing the patient-centered medical home model as an integral part of the Medicare program. The academy advocates for a new Medicare physician payment system that embraces the following: Adoption of the medical home model that provides a per-month care management fee for physicians whom patients designate as their patient-centered medical home; continued use of the resource-based relative value scale using a conversion factor updated annually by the Medicare economic index; no geographic adjustment in Medicare allowances except as it relates to identified shortage areas; a phased-in voluntary pay-for-performance system consistent with the IOM recommendations.

The academy commends the committee for its consideration of incorporating the medical home concept within Medicare physician payment reform and, based on the existing literature, would urge the committee to move beyond a demonstration project to permanent adoption of this model by authorizing CMS to promulgate regulations to make the patient-centered medical home a permanent part of Medicare.

The academy also commends Chairman Barton, Ranking Member Dingell, Subcommittee Chairman Deal, and Dr. Burgess for their initiatives in attempting to identify a more aligned and contemporary Medicare payment methodology for physician services.

And the academy is eager to work with the committee toward the needed system improvements in the efficiency of the program and also in the quality and effectiveness of the services delivered to our Nation's elderly. Thank you very much.

[The prepared statement of Dr. Weida follows:]

PREPARED STATEMENT OF DR. THOMAS J. WEIDA, SPEAKER, AMERICAN ACADEMY OF  
FAMILY PHYSICIANS

**Introduction**

Mr. Chairman and members of the committee, I am Dr. Tom Weida, Speaker of the Congress of Delegates of the American Academy of Family Physicians (AAFP). I am pleased to be here to testify on an issue of critical importance to the 94,000 members of the American Academy of Family Physicians and the patients we serve.

The AAFP appreciates the Committee's commitment to avoid the looming 5.1 percent payment reduction for fiscal year 2007 and to put plans in place to replace the current unsustainable payment system. We would like to take the opportunity to discuss the provisions of the legislation.

The AAFP appreciates the work this committee has undertaken to examine how Medicare pays for services physicians deliver to Medicare beneficiaries and we share the subcommittee's concerns that the current system is flawed, outdated and unsustainable. For this reason the AAFP supports the restructuring of Medicare payments to reward quality and care coordination. Such a restructuring must be built on a fundamental reform of the underlying fee-for-service system and a revaluing of the services offered by all physicians providing care.

Most Americans receive the majority of their health care in primary care settings. These are often small or medium size practices. Specifically, about a quarter of all office visits in the U.S. are to family physicians, and Medicare beneficiaries comprise about a quarter of the typical family physician's practice. Finding a more efficient and effective method of paying for physicians' services delivered in such diverse settings to Medicare patients with a large variety of health conditions is a difficult but necessary, and one that has tremendous implications for millions of patients and for the specialty of family medicine. The Academy, therefore, is committed to involvement in the design of a new payment system that meets the needs of patients and physicians.

**Current Payment Environment**

The environment in which U.S. physicians practice and are paid is challenging at best. Medicare, in particular, has a history of making disproportionately low payments to family physicians, largely because its payment formula is based on a reimbursement scheme that rewards procedural volume and fails to foster comprehensive, coordinated management of patients. More broadly, the prospect of steep annual cuts in payment resulting from the flawed payment formula is, at best, discouraging. In the current environment, physicians know that, without Congressional action, they will face a 5.1 percent cut in January 2007. Clearly, the Sustainable Growth Rate (SGR) formula does not work.

Under the SGR, physicians face steadily declining payments into the foreseeable future – nearly 40 percent over the next six years-- even while their practice costs

continue to increase. According to the government's own calculations, the Medicare payment rate for physician services has for several years not kept pace with the cost of operating a small business which delivers medical care.

### **Primary Care Physicians in the U.S.**

While other developed countries have a better balance of primary care doctors and subspecialists, primary care physicians make up less than one-third of the U.S. physician workforce. Compared to those in other developed countries, Americans spend the highest amount per capita on healthcare but have some of the worst healthcare outcomes. More than 20 years of evidence shows that having a primary care-based health system has both health and economic benefits. Two years ago, a study comparing the health and economic outcomes of the physician workforce in the U.S. reached the same conclusion (*Health Affairs*, April 2004). By not using a system of health care based on primary care physicians coordinating patients' care, the U.S. health care system pays a steep price.

### **Aligning Incentives**

Beyond replacing the outdated and dysfunctional SGR formula, a workable, predictable method of determining physician reimbursement, one that is sensitive to the costs of providing care, should align the incentives to encourage evidence-based practice and foster the delivery of services that are known to be more effective and result in better health outcomes for patients. Moreover, the reformed system must facilitate efficient use of Medicare resources by paying for appropriate utilization of effective services and not paying for services that are unnecessary, redundant or known to be ineffective. Such an approach is endorsed by the Institute of Medicine (IOM) in its 2001 publication *Crossing the Quality Chasm*.

Another IOM report released just last week entitled *Rewarding Provider Performance: Aligning Incentives in Medicare* states that aligning payment incentives with quality improvement goals represents a promising opportunity to encourage higher levels of quality and provide better value for all Americans. The objective of aligning incentives through pay for performance is to create payment incentives that will: (1) encourage the most rapid feasible performance improvement by all providers; (2) support innovation and constructive change throughout the health care system; and (3) promote better outcomes of care, especially through coordination of care across provider settings and time. The Academy concurs with the IOM recommendations that state:

- Measures should allow for shared accountability and more coordinated care across provider settings.
- P4P programs should reward care that is patient-centered and efficient. And reward providers who improve performance as well as those who achieve high performance.
- Providers should be offered (adequate) incentives to report performance measures.
- Because electronic health information technology will increase the probability of a successful pay-for-performance program, the Secretary should explore ways to assist providers in implementing electronic data collection and reporting to strengthen the use of consistent performance measures.

AAFP concurs with these IOM recommendations.

Aligning the incentives requires collecting and reporting meaningful quality measures. AAFP is supportive of collecting and reporting quality measures and has demonstrated leadership in the physician community in the development of such measures. It is the Academy's belief that measures of quality and efficiency should include a mix of outcome, process and structural measures. Clinical care measures must



be evidence-based and physicians should be directly involved in determining the measures used for assessing their performance.

### **Care Coordination and a Patient-Centered Medical Home**

From the outset, the Medicare program has based physician and supplier payment on a fee-for-service system. This example of non-aligned incentives has produced distortions by rewarding individual physicians for ordering tests and performing procedures. The system lacks incentive for physicians to coordinate the tests, procedures, or patient health care generally, including preventive services or care to maintain health. This payment method has resulted in an expensive, fragmented Medicare program.

This out-of-date payment scheme does not adequately compensate physicians who do manage and organize their patients' health care. Currently, there is no direct compensation to physicians for the considerable time and effort associated with coordinating health care in a way that is understandable to patients and cost-effective for the Medicare program.

To correct these inverted incentives, the American Academy of Family Physicians recommends Medicare compensate physicians for care coordination services. Such payment should go to the personal physician chosen by the patient to perform this role. Any physician practice prepared to provide care coordination could be eligible to serve as a patient's medical home.

In its reports, the Institute of Medicine (IOM) has repeatedly praised the value of, and cited the need for, care coordination. And while there are a number of possible methods to build this into the Medicare program, AAFP recommends a blended model that combines fee-for-service with a per-beneficiary, per-month stipend for care coordination in addition to meaningful incentives for delivery of high-quality and effective services. Patients should be given incentives to select a personal medical home by reduced out-of-pocket expenses such as co-pays and deductibles.

The more efficient payment system should place greater value on cognitive and clinical decision-making skills that result in more efficient use of resources and that result in better health outcomes. For example, the work of Barbara Starfield, Ed Wagner and others has shown that patients, particularly the elderly, who have a usual source of care, are healthier and cost less because they use fewer medical resources than those who do not. The evidence shows that even the uninsured benefit from having a usual source of care (or medical home). These individuals have more physician visits, get more appropriate preventive care and receive more appropriate prescription drugs than those without a usual source of care, and do not get their basic primary health care in a costly emergency room, for example. In contrast, those without this usual source have more problems getting health care and neglect to seek appropriate medical help when they need it. A more efficient payment system would encourage physicians to provide patients with a medical home in which a patient's care is coordinated and expensive duplication of services is eliminated.

A reimbursement system with appropriate incentives for the patient and the physician recognizes the time and effort involved in ongoing care management. The Academy commends the committee for its consideration of incorporating the medical home concept into Medicare physician payment reform and, based on the existing literature, would urge the committee to move beyond a demonstration project to permanent adoption of this model by authorizing the Centers for Medicare and Medicaid Services (CMS) to make the Patient-centered Medical Home a permanent part of Medicare.

The patient-centered, physician-guided medical home being advanced jointly by the American Academy of Family Physicians and the American College of Physicians would include the following elements:

- **Personal physician** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- **Physician directed medical practice** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- **Whole person orientation** – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- **Care is coordinated and/or integrated** across all domains of the health care system (hospitals, home health agencies, nursing homes, consultants and other components of the complex health care system), facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it.
- **Quality and safety** are hallmarks of the patient-centered medical home:

Evidence-based medicine and clinical decision-support tools guide decision making. Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement. Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met.

Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication.

Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.

- **Enhanced access** to care through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and office staff.

Payment of the care management fee for the medical home would reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit associated with patient-centered care management, and it would pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources. The per beneficiary, per month stipend should be at least \$15, which reflects an average among chronic disease management programs offered by private payers (*AAFP Task Force on the Future of Family Medicine*). Most Medicare beneficiaries have one or more chronic illnesses.

Finally, given the increasing prevalence of pay-for-performance in the public and private sector and the advent of Medicare's Physician Voluntary Reporting Program, the AAFP believes the Medicare physician payment system should include a phased-in performance bonus based for voluntary reporting of quality improvement measures.

### Reporting

AAFP is supportive of collecting and reporting quality measures and has led the physician community in the development of meaningful measures. Consistent with the

philosophy of aligning incentives, the reward for collecting and reporting data must be commensurate with the effort and processes necessary to comply and must be sufficient to obtain the desired response from providers. The Academy believes that one currently contemplated incentive of a quarter of a percent (0.25 percent) for reporting quality would fall short of covering the actual cost of operationalizing such a mandate and is therefore insufficient incentive for participation.. Moreover, CMS has indicated it does not have processes in place to collect, analyze and determine payment on such data by the first of the year. Thus, we are concerned that mandating the collection and submission of quality measures without the administrative infrastructure to be able to reward such data collection and reporting efforts could be counter productive.

To realize the benefits of such a program, it is critical to provide a sound foundation and to have parameters in place to allow data to be effectively analyzed. In addition, legislation should provide adequate incentives to encourage the maximum number of participants to gather a true sample of the population served by the program.

The AAFP supports efforts to transition to value-based purchasing to improve the quality of patient care. We believe that quality, access and positive health outcomes must be the primary goal of any physician reimbursement system. Prevention, early diagnosis and early treatment will simultaneously improve quality of life and ultimately save valuable health care dollars. But implementing data collection and reporting requires an initial investment from the health care provider in the form of electronic data and decision support systems.

#### **A Chronic Care Model in Medicare**

If we do not change the Medicare payment system, the aging population and the rising incidence of chronic disease will overwhelm Medicare's ability to provide health care. Currently, 82 percent of the Medicare population has at least one chronic condition and two-thirds have more than one illness. However, the 20 percent of beneficiaries with five or more chronic conditions account for two-thirds of all Medicare spending. There is strong evidence the *Chronic Care Model* (Ed Wagner, Robert Wood Johnson Foundation) would improve health care quality and cost-effectiveness, integrate patient care, and increase patient satisfaction. This well-known model is based on the fact that most health care for the chronically ill takes place in primary care settings, such as the offices of family physicians. The model focuses on six components:

- self-management by patients of their disease
- an organized and sophisticated delivery system
- strong support by the sponsoring organization
- evidence-based support for clinical decisions
- information systems; and
- links to community organizations.

This model, with its emphasis on care-coordination, has been tested in some 39 studies and has repeatedly shown its value. While we believe reimbursement should be provided to any physician who agrees to coordinate a patient's care (and serve as a medical home), generally this will be provided by a primary care doctor, such as a family physician. According to the Institute of Medicine, primary care is "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community." Family physicians are trained specifically to provide exactly this sort of coordinated health care to their patients.

The AAFP advocates for a new Medicare physician payment system that embraces the following:

- Adoption of the Medical Home model which would provide a per month care management fee for physicians whom beneficiaries designate as their Patient-centered Medical Home;
- Continued use of the resource-based relative value scale (RBRVS) using a conversion factor updated annually by the Medicare Economic Index (MEI);
- No geographic adjustment in Medicare allowances except as it relates to identified shortage areas;
- A phased-in voluntary pay-for-reporting, then pay-for-performance system consistent with the IOM recommendations.
  - *Phase 1:* “Pay for reporting” based on structural and system changes in practice (e.g., electronic health records and registries)
  - *Phase 2:* “Pay for reporting” of data on evidence-based performance measures that have been appropriately vetted through mechanisms such as the Physician Consortium for Performance Improvement and the Ambulatory Care Quality Alliance (AQA), without regard to outcomes achieved
  - *Phase 3:* Incentive payments to physicians for demonstrated improvements in outcomes and processes, using evidence-based measures; e.g., the AQA starter set.

#### **Value-Based Purchasing – Development of Quality Measures**

The AAFP supports moving to value-based purchasing (pay-for-performance) in Medicare if the central purpose is to improve the quality of patient care and clinical outcomes. As we have stated previously in a joint letter to Congress with our colleague organizations American College of Physicians (ACP), American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG), “we believe that the medical profession has a professional and ethical responsibility to engage in activities to continuously improve the quality of care provided to patients... Our organizations accept this challenge.” We have committed to work for the improvement of the practice of family medicine, to strengthen the infrastructure of medical practice to support appropriate value-based purchasing, and to engage in development and validation of performance measures.

While several specific issues remain that must be addressed in implementing pay-for-performance in Medicare, the AAFP has a framework for a phased-in approach for Medicare consistent with IOM recommendations.

First, the development of valid, evidence-based performance measures is imperative for a successful program to improve health quality. The AAFP participates actively in the development of performance measures through the Physician Consortium. We believe multi-specialty collaboration in the development of evidence-based performance measures through the consortium has yielded and will continue to yield valid measures for quality improvement and ultimately pay-for-performance. In addition, these measures should provide consistency across all specialties.

Secondly, the National Quality Forum (NQF) or an NQF-like entity can review and clear valid quality measures developed by the Physician Consortium. With its multi-stakeholder involvement and its explicit consensus process, the NQF provides essential credibility to the measures it approves – measures developed by the Physician Consortium.

Lastly, the Ambulatory Care Quality Alliance (AQA) of which AAFP is a founding organization (along with the ACP, America’s Health Insurance Plans and the Agency for Healthcare Research and Quality) determines which of the measures approved through the NQF consensus process should be implemented initially and which should then be added so that there is a complete set of measures, including those relating to efficiency, sub-specialty performance, and patient experience.

Having a single set of measures that can be reported by a practice to different health plans with which the practice is contracted is critical to reducing the reporting costs borne by medical practices. Measures that ultimately are utilized in a Medicare pay-for-performance program should follow this path.

#### **Information Technology in the Medical Office Setting**

An effective, accurate and administratively operational pay-for-performance program is predicated on the presence of health information technology in the physician's office. Using advances in health information technology (HIT) also aids in reducing errors and allows for ongoing care assessment and quality improvement in the practice setting – two additional goals of recent IOM reports. We have learned from the experience of the Integrated Healthcare Association (IHA) in California that when physicians and practices invested in electronic health records (EHRs) and other electronic tools to automate data reporting, they were both more efficient and more effective, achieving improved quality results at a more rapid pace than those that lacked advanced HIT capacity.

Family physicians are leading the transition to EHR systems in large part due to the efforts of AAFP's Center for Health Information Technology (CHiT). The AAFP created the CHiT in 2003 to increase the availability and use of low-cost, standards-based information technology among family physicians with the goal of improving the quality and safety of medical care and increasing the efficiency of medical practice. Since 2003, the rate of EHR adoption among AAFP members has more than doubled, with over 30 percent of our family physician members now utilizing these systems in their practices. In an HHS-supported EHR Pilot Project conducted by the AAFP, we learned that practices with a well-defined implementation plan and analysis of workflow and processes had greater success in implementing an EHR. CHiT used this information to develop a practice assessment tool on its Website, allowing physicians to assess their readiness for EHRs.

In any discussion of increasing utilization of an EHR system, there are a number of barriers and cost is a top concern for family physicians. The AAFP has worked aggressively with the vendor community through our Partners for Patients Program to lower the prices of appropriate information technology. The AAFP's Executive Vice President serves on the American Health Information Community (AHIC), which is working to increase confidence in these systems by developing recommendations on interoperability. The AAFP sponsored the development of the Continuity of Care Record (CCR) standard, now successfully balloted through the American Society for Testing and Materials (ASTM). We initiated the Physician EHR Coalition, now jointly chaired by ACP and AAFP, to engage a broad base of medical specialties to advance EHR adoption in small and medium size ambulatory care practices. In preparation for greater adoption of EHR systems, every family medicine residency will implement EHRs by the end of this year.

To accelerate reporting, the AAFP joins the IOM in encouraging federal funding for health care providers to purchase HIT systems. According to the US Department of Health & Human Services, billions of dollars will be saved each year with the widespread adoption of HIT systems. The federal government has already made a financial commitment to this technology; unfortunately, the funding is not directed to the systems that will truly have the most impact and where ultimately all health care is practiced - at the individual patient level. We encourage you to include funding in the form of grants or low interest loans for those physicians committed to integrating an HIT system in their practice.

#### **A Framework for Pay-for-performance**

The following is a proposed framework for phasing in a Medicare pay-for-

performance program for physicians that is designed to improve the quality and safety of medical care for patients and to increase the efficiency of medical practice.

- *Phase 1*  
All physicians would receive a positive update in 2007, based on recommendations of MedPAC, reversing the projected 5.1-percent reduction. Congress should establish a floor for such updates in subsequent years.
- *Phase 2*  
Following completion of development of reporting mechanisms and specifications, Medicare would encourage structural and system changes in practice, such as electronic health records and registries, through a “pay for reporting” incentive system such that physicians could improve their capacity to deliver quality care. The update floor would apply to all physicians.
- *Phase 3*  
Assuming physicians have the ability to do so, Medicare would encourage reporting of data on evidence-based performance measures that have been appropriately vetted through mechanisms such as the National Quality Forum and the Ambulatory Care Quality Alliance. During this phase, physicians would receive “pay for reporting” incentives; these would be based on the reporting of data, not on the outcomes achieved. The update floor would apply to all physicians.
- *Phase 4*  
Contingent on repeal of the SGR formula and development of a long term solution allowing for annual payment updates linked to inflation, Medicare would encourage continuous improvement in the quality of care through incentive payments to physicians for demonstrated improvements in outcomes and processes, using evidence-based measures; e.g., the provision of preventive services, performing HbA1c screening and control for diabetic patients and prescribing aspirin for patients who have experienced a coronary occlusion. The update floor would apply to all physicians.

This type of phased-in approach is crucial for appropriate implementation. While there is general agreement that initial incentives should foster structural and system improvements in practice, decisions about such structural measures, their reporting, threshold for rewards, etc., remain to be determined. The issues surrounding collection and reporting of data on clinical measures are also complex. For example, do incentives accrue to the individual physician or to the entire practice, regardless of size. In a health care system where patients see multiple physicians, to which physician are improvements attributed.

The program must provide incentives – not punishment – to encourage continuous quality improvement. For example, physicians are being asked to bear the costs of acquiring, using and maintaining health information technology in their offices, with benefits accruing across the health care system – to patients, payers and insurance plans. Appropriate incentives must be explicitly integrated into a Medicare pay-for-performance program if we are to achieve the level of infrastructure at the medical practice to support collection and reporting of data.

### **Conclusion**

The AAFP encourages Congressional action to reform the Medicare physician reimbursement system in the following manner:

- Repeal the Sustainable Growth Rate formula at a date certain and replace it with a stable and predictable annual update based on changes in the costs of providing care as calculated by the Medicare Economic Index.

- Adopt the patient-centered medical home by giving patients incentives to use this model and compensate physicians who provide this function. The physician designated by the beneficiary as the patient-centered medical home shall receive a per-member, per-month stipend in addition to payment under the fee schedule for services delivered.
- Begin to phase in value-based purchasing by starting with a pay-for-reporting program. Compensation for reporting must be sufficient to cover costs associated with the program and provide a sufficient incentive to report the required data.
- Ultimately, payment should be linked to health care quality and efficiency and should reward the most effective patient and physician behavior.

The Academy commends the subcommittee for its commitment to identify a more accurate and contemporary Medicare payment methodology for physician services. Moreover, the AAFP is eager to work with Congress toward the needed system changes that will improve not only the efficiency of the program but also the effectiveness of the services delivered to our nation's elderly.

MR. DEAL. Thank you.

Dr. Wilson you are recognized.

DR. WILSON. Well, thank you, Mr. Chairman.

My name is Cecil Wilson. I am chair of the Board of Trustees of the American Medical Association and also an internist in practice in Winterpark, Florida. On behalf of the AMA, I commend you, Chairman Barton, Mr. Dingell, Dr. Burgess and members of the subcommittee for your leadership in addressing the Medicare physician payment problem, and we look forward to continuing to work with you.

The Medicare physician payment system is broken. You have heard that physicians face drastic payment cuts of almost 40 percent over the next 9 years due to the flawed sustainable growth rate formula, while practice costs are projected to increase about 20 percent during the same period. And that is not all. These cuts follow 5 years of payment updates that have not kept pace with medical practice cost increases. Payments in 2006 are at about the same level as in 2001. A 5 percent cut is scheduled for January 1, 2007, and other Medicare payment policy changes in 2007, as you have heard, will exacerbate the cut for as many as half of all physicians.

For example, 45 percent of Texas physicians will face cuts ranging from 6 to 15 percent; 5 percent will see even steeper cuts of 16 to 20 percent, and we fear patient access will suffer. An AMA survey this year shows that 45 percent, almost half of physicians, have indicated they will be forced to limit the number of new Medicare patients they can accept if the 5 percent cut takes effect in January.

In addition, more than 35 States will lose in excess of \$1 billion each by 2015. For example, Texas will lose \$13 billion; Michigan over \$8 billion. Time is running out. As you know, 265 members of this

House signed a letter urging passage of legislation before adjournment to provide physicians with Medicare payments that reflect increases in medical practice costs. The AMA urges Congress to act. We support a multiyear SGR solution instead of the 3 years of modest updates in the committee draft. We would urge a modification to include 2 years of higher updates that could reflect practice cost increases.

And we do appreciate that the committee draft sets forth a framework for physicians to report quality information under Medicare and have the following comments:

First, instead of designating those structural measures for which physicians would report data, we would suggest that the draft should establish a specific process by which such measures could be developed by physicians through the Physician Consortium for Performance Improvement.

The AMA's convened consortium is a physician consensus-building organization with over 100 national medical societies, State medical societies and special societies. The AMA is fulfilling and exceeding our commitment regarding development of quality measures. As promised, the consortium has to date developed 98 quality measures with an additional 70 expected by the end of the year. The consortium will, in addition, use the 2007 ramp-up period to expand the scope of these measures including developing structural measures to ensure that a broad cross-section of physicians could participate in the reporting program.

Second, the AMA agrees that the reporting program should be voluntary. Third, the program should provide payments to offset physicians' administrative costs in reporting data. And fourth, the AMA supports the concept of the medical home demonstration and would recommend expansion to specialties in addition to primary care.

And finally, it is critical that Congress recognize that a quality improvement program is incompatible with the use of the SGR. Quality improvements may save dollars for the Medicare program as a whole by avoiding costly Part A hospitalizations and readmissions. The dilemma is that this will increase Part B spending, and under the SGR, this triggers physician payment cuts.

So, in order to maintain access to the highest quality of care for our Medicare patients, we urge Congress to act promptly to ensure a positive payment update in 2007 and make progress toward a long-term solution, both of which should reflect increases in medical practice costs and support a voluntary program of participation and quality improvement. The AMA looks forward to working with the subcommittee to achieve our shared goals, and thank you for the opportunity to be here today.

[The prepared statement of Dr. Wilson follows:]



PREPARED STATEMENT OF DR. CECIL B. WILSON, CHAIR, BOARD OF TRUSTEES, AMERICAN  
MEDICAL ASSOCIATION

The American Medical Association (AMA) appreciates the opportunity to provide our views regarding "Medicare Physician Payments: 2007 and Beyond." We commend you, Chairman Barton, Mr. Deal, Mr. Dingell, and Members of the Subcommittee, for all your hard work and leadership in recognizing the fundamental need to address the fatally flawed Medicare physician payment update formula, called the sustainable growth rate, or SGR, and avert the 5% physician payment cut scheduled for 2007.

**MEDICARE PHYSICIAN CUTS IN 2007 AND BEYOND**

**Congress Must Act Now To Avert Pay Cuts in 2007**

The AMA is grateful to the Subcommittee and Congress for taking action in each of the last four years to forestall steep Medicare physician payment cuts, due to the flawed SGR physician payment formula. Yet, a crisis still looms, and, in fact, is getting worse.

**Payments to physicians today are essentially the same as they were five years ago. Yet, due to the SGR, physicians now face drastic Medicare payment cuts totaling almost 40% over the next nine years. The first of these cuts is scheduled to take effect on**

**January 1, 2007, and according to surveys by the American Medical Association (AMA) and Medical Group Management Association (MGMA), 45% of physicians and 40% of group practices will be forced to limit the number of new Medicare patients they can accept when the first cut of at least 5% goes into effect January 1, 2007. Time is running out, and Congress needs to act promptly to avert the 2007 physician pay cut by enacting a positive physician payment update that accurately reflects increases in medical practice costs, as indicated by the Medicare Economic Index (MEI).**

**Further, over the long-term, Congress must repeal the SGR and replace it with a system that keeps pace with increases in medical practice costs.**

**Congress Must Repeal the SGR and Avert Long-Term Pay Cuts Over Nine Years**

As this Subcommittee focuses its attention on Medicare, we appreciate the efforts of the Full and Subcommittee to address the problems due to the SGR. In addition to the Subcommittee's efforts, there is widespread consensus that the SGR formula needs to be repealed: (i) there is bipartisan recognition in this Subcommittee and Congress that the SGR, with its projected physician pay cuts, must be replaced with a formula that reflects increases in practice costs; (ii) MedPAC has recommended that the SGR be replaced with a system that reflects increases in practice costs, with an update equivalent to the MEI for 2007; (iii) CMS Administrator McClellan has stated that the current physician payment system is "not sustainable;" and (iv) the Military Officers Association of America (MOAA) has stated that payment cuts under the SGR would significantly damage military beneficiaries' access to care under TRICARE, which will have long-term retention and readiness consequences. Further, 265 Representatives signed a letter calling on House leaders to pass legislation before they adjourn this week to provide physicians with Medicare payments that reflect increases in medical practice costs.

The AMA looks forward to working with the Subcommittee and Congress to repeal the SGR and replace it with a system that adequately keeps pace with increases in medical practice costs. We emphasize that every time action to repeal the SGR has been postponed, the cost of the next solution, whether short- or long-term, has become

significantly higher and increased the risk of a complete meltdown in Medicare patients' access to care.

Beginning January 1, 2007, and extending over the next nine years, almost 200 billion dollars will be cut from payments to physicians for care provided to seniors – just as baby boomers are aging into Medicare by the millions. These cuts follow five years of congressional intervention to prevent the cuts and modest updates that have not kept up with practice cost increases, and payment rates in 2006 remain about the same as in 2001. *Data in CMS' rule on the "Five-Year Review of Relative Value Units Under the Physician Fee Schedule and Proposed Changes to the Practice Expense Methodology," proposed earlier this year, indicate that Medicare now covers only two-thirds of the labor, supply and equipment costs that go into each service.*

Only physicians and other health professionals face steep cuts under this flawed payment formula. Other providers have been receiving updates that fully keep pace with their costs (and will continue to do so under current law), including Medicare Advantage plans which are already paid 11% in excess of fee-for-service costs. Physicians and other health care professionals (whose payment rates are tied to the physician fee schedule) must have payment equity with these other providers. Physicians are the foundation for our nation's health care system, and thus a stable payment environment for their services is critical.

Finally, in addition to the 2007 physician cuts due to the flawed SGR, other Medicare physician payment policy changes will take effect on January 1, 2007. These changes were discussed at length in our July testimony and relate to: (i) expiration of the MMA provision that increased payments in 58 of the 89 Medicare payment localities; and (ii) recent CMS proposals that will change both the "work" and "practice expense" relative values, each of which are components in calculating Medicare physician payments for each individual medical service; and (iii) payment cuts in imaging services furnished in physicians' offices, as mandated by the Deficit Reduction Act of 2005.

These policy changes will have a significant impact on a large number of physicians who could experience combined pay cuts of 10% or more for many physicians' services. In fact, a recent AMA analysis indicates that if the 5% SGR cut is allowed to take effect in 2007, 13% of physicians will face cuts exceeding 10% and 32% will see cuts of 6% to 10%. We caution the Subcommittee that, taken together, all of the foregoing cuts will make it nearly impossible for most physicians to make the necessary financial investment and staff commitment to participate in quality improvement programs. The medical profession has made significant investment and progress over the past few years in the development of a system that enhances the quality of care in this country. If that momentum is to be maintained, however, Congress now must do its part by providing physicians with an adequate payment system that supports that goal.

#### Spending Targets Do Not Achieve their Goal of Restraining Volume Growth

Some have argued that the SGR formula is needed to restrain the growth of Medicare physicians' services. The AMA disagrees. As discussed extensively in our written testimony presented to this Subcommittee in July, spending targets, such as the SGR, cannot achieve their goal of restraining volume growth by discouraging inappropriate care.

**If there is a problem with inappropriate volume growth regarding a particular type of medical service, Congress and CMS should address it through targeted actions that deal with the source of the increase.**

## **ACCESS PROBLEMS FOR MEDICARE BENEFICIARIES UNDER THE SGR**

### **AMA Survey Shows Patient Access Will Significantly Decline if the Projected SGR Cuts Take Effect**

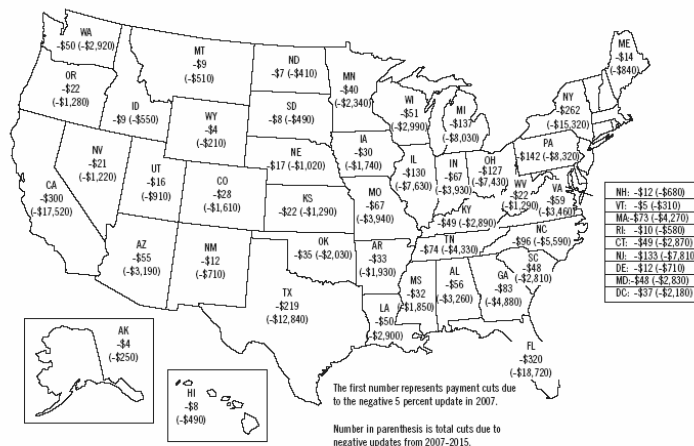
Physicians cannot continue to absorb the draconian Medicare cuts that are projected for 2007 through 2015, especially when medical practice costs are projected to increase about 20% during this same time period, as estimated by the governments' own conservative measure. A recent AMA survey, as presented to the Subcommittee in our July testimony, confirmed that patient access will suffer as a result.

Further, a recent national poll conducted by the AMA shows that the vast majority of Americans, 86% are concerned that seniors' access to health care will be hurt if impending cuts in Medicare physician payment take effect on January 1, 2007. Further, 82% of current Medicare patients are concerned about the cuts impact on their access to health care. Baby boomers are also very concerned about the impact of the cuts on Medicare patients' access to care. A staggering 93% of baby boomers age 45-54 are concerned about the cuts impact on access to care. In just five years, the first wave of baby boomers will reach age 65, and will turn to Medicare for their health care.

### **IMPACT OF PROJECTED SGR CUTS ON INDIVIDUAL STATES**

If Congress allows the pay cuts forecast by the Medicare Trustees to go into effect, there will be serious consequences in each state across the country. As the map below illustrates, more than 35 states will see their health care funds reduced by more than one billion dollars by the time the cuts end in 2015. Florida and California are the biggest losers, with each of these states losing close to \$300 million in 2007 alone. Medicare payments in Florida would be cut by more than \$18 billion from 2007-2015; California will lose more than \$17 billion over the 9-year period, and Texas is not far behind with nearly \$13 billion in cuts. Ohio is facing losses of more than \$7 billion and Georgia will see about \$5 billion in cuts.

### **Medicare cuts for physician services 2007-2015 (in millions)**



Sources: The projected negative Medicare physician payment updates are from the CMS Office of the Actuary and the 2006 Medicare Trustees Report. The source of the state-by-state analysis is the American Medical Association Division of Economic and Statistical Research, August 2006.

Seniors cannot afford to have their access to physicians jeopardized by further reducing Medicare payment rates below the increasing costs of running medical practices. Ohio's 1.6 million Medicare beneficiaries comprise 14% of the state's population and Florida's nearly 3 million beneficiaries are 16% of its population. Even before the forecast cuts go into effect, Georgia only has 208 practicing physicians per 100,000 population and Texas has 207 practicing physicians per 100,000 population, which means both states are far below the national average of 256. Florida only has 15 practicing physicians for every 1,000 Medicare beneficiaries, 25% below the national average.

The negative effects of the cuts in the Medicare physician payment schedule are not only felt by patients, but also by the millions of employees that are involved in delivering health care services in every community. Data from the Bureau of Labor Statistics show that the physician payment cuts will affect: 80,274 employees in Georgia; 112,176 employees in Ohio; 195,288 employees in Florida; 200,469 employees in Texas; and 292,171 employees in California.

**We urge the Subcommittee to avoid the serious consequences for patients that will occur if the projected SGR cuts take effect, and establish a Medicare physician payment system that helps physicians serve patients by providing payment updates that recognize continual increases in cost of providing care and incentives needed to invest in HIT and quality improvement programs.**

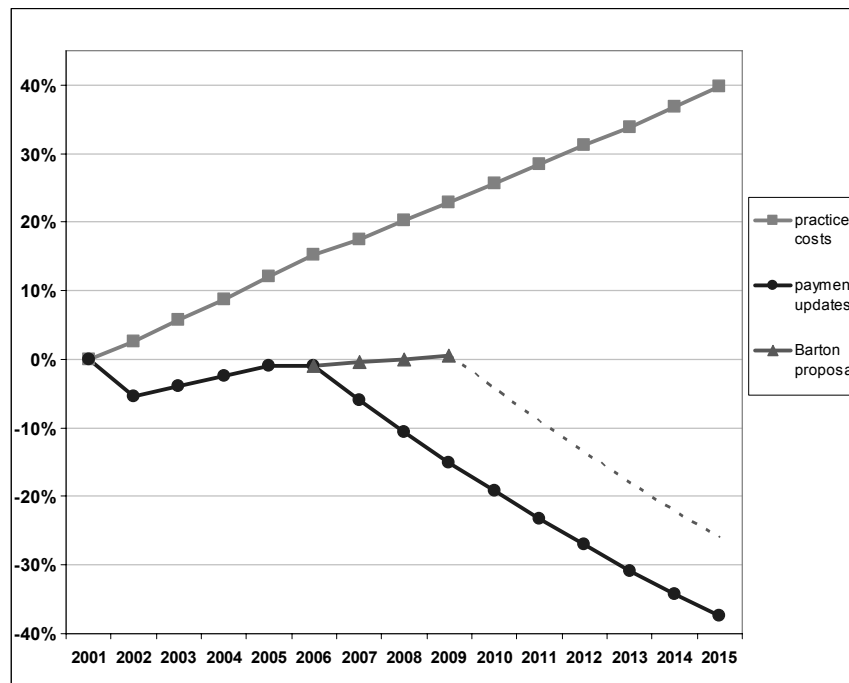
#### **LEGISLATIVE PROPOSALS TO ADDRESS THE SGR**

The AMA appreciates the efforts of Chairman Barton and Members of the Subcommittee and their staffs to address the projected physician pay cuts, caused by the flawed SGR formula. This update formula for physicians' services is broken beyond repair and needs to be replaced with a new system. Indeed, Chairman Barton and other Members of the Subcommittee have expressed the need to repeal the SGR, and legislation currently being developed by the Chairman would set the stage and allow Congress time to achieve this goal. In addition, H.R. 5866, the "Medicare Physician Payment Reform and Quality Improvement Act of 2006" introduced by Rep. Burgess (R-TX), would repeal the SGR and replace it with a payment system that is based on the MEI. Finally, Ranking Member Dingell's legislation, H.R. 5916, the "Patients' Access to Physicians Act of 2006," would ensure that physicians would be paid at least the percentage increase in the MEI in 2007 and 2008.

We appreciate that each of these bills would take an important step in preserving patient access to high quality medical care by addressing the flawed SGR and implementing positive payment updates for physicians. **While the AMA supports a multi-year physician payment solution, we understand that funding for such a solution is limited. Therefore, we urge the Subcommittee to consider legislation that would provide physicians with updates over two years that reflect practice cost increases, as measured by the MEI, instead of longer-term solutions with more modest updates.** Such updates are needed to cover increases in medical practice costs, especially since updates over the last five years have fallen far behind increases in such costs. An additional payment for reporting quality data, as discussed further below, should also be provided along with these updates. Finally, we urge that any legislation providing positive physician updates be fully funded up front, and any offsets to cover the cost of these updates should not come from Medicare Part B services, as this would undermine the impact of a positive payment update.

The chart below shows the gap in Medicare payment to physicians from 2001 through 2015, as compared to increases in medical practice costs under the MEI, as well as the payment updates for 2007 through 2009 set forth in Chairman Barton's proposal.

**Physician Cost Increases vs. Physician Payment Updates  
Under the SGR Formula: 2001-2015**



We look forward to continuing our work with Congress to achieve this year our shared goals of averting the 2007 Medicare physician payment cut and adequately addressing the SGR to ensure that future physician payment updates reflect the MEI and keep pace with increases in medical practice costs.

**QUALITY IMPROVEMENT LEGISLATIVE PROPOSALS**

Chairman Barton's legislative proposal to address the SGR, as well as Representative Burgess' bill, H.R. 5866, would also implement a voluntary quality reporting program for physicians under Medicare. The AMA has supported the advancement of quality care since our inception and that goal remains paramount to the AMA and its physician members today.

**We applaud the efforts of Chairman Barton and Representative Burgess, and respectfully urge Congress to consider the following comments as it moves forward with quality reporting legislation.**

**Quality Improvement Programs Cannot Co-Exist with the SGR**

It is important to recognize that the current Medicare physician payment update formula cannot coexist with a payment system that rewards improvement in quality. Quality improvements are aimed largely at eliminating gaps in care and are far more likely to increase rather than decrease utilization of physician services. Specifically,

quality improvements are expected to encourage more preventive care and better management of chronic conditions. While such results would reduce spending for hospital services covered by Part A of Medicare, they do so by increasing spending for the Medicare Part B physicians' services that are included in the SGR. In fact, data from the Medicare Payment Advisory Commission (MedPAC) suggest that some part of the recent growth in Medicare spending on physicians' services is associated with improved quality of care.

Increased Medicare spending on physician services, however, conflicts with the SGR, which imposes an arbitrary target on Medicare physician spending and results in physician pay cuts when physician spending exceeds the target. Thus, additional and appropriate physician services encouraged under a quality reporting program will result in more physician pay cuts.

Further, pay-for-performance programs depend on greater physician adoption of information technology at great cost to physician practices. A study by Robert H. Miller and others found that initial electronic health record costs were approximately \$44,000 per full-time equivalent (FTE) provider per year, and ongoing costs were about \$8,500 per FTE provider per year. (*Health Affairs*, September/October, 2005). Initial costs for 12 of the 14 solo or small practices surveyed ranged from \$37,056 to \$63,600 per FTE provider. Without positive payment updates, it will be difficult for physicians to make these HIT investments. In fact, a 2006 AMA survey shows that if the projected nine years of cuts take effect, 73% of responding physicians will defer purchase of new medical equipment, and 65% will defer purchase of new information technology. Even with just one year of cuts, half of the physicians surveyed will defer purchases of information technology.

**We urge the Subcommittee to ensure that any quality reporting program is premised on: (i) positive and adequate physician payment updates that reflect increases in medical practice costs; and (ii) additional payments that fully offset physicians' administrative costs in reporting quality data and thus provide an incentive to report.**

Quality Improvement Legislation Should Establish a Specific  
Process for Developing Measures for Which Physicians Report Data

Chairman Barton's proposal provides a framework with certain options to allow physicians to report quality information under the Medicare program. To enhance this framework even further, we encourage certain refinements of the proposal.

**We urge that the Chairman's proposal establish a specific process for designating the measures for which physicians are to report data. The legislation should also specifically provide that under this process:**

- Clinical and structural measures would be developed by the physician medical specialty societies through the Physician Consortium on Performance Improvement (the Consortium).
- Measures must be: (i) evidence-based, and developed collaboratively across physician specialties; (ii) consistent, valid, practicable, and not overly burdensome to collect; and (iii) relevant to physicians and other practitioners, and Medicare beneficiaries.
- The Secretary would adopt and publish the Consortium measures for the Medicare program and could not make modifications without the Consortium's consent.
- Solo physicians or group practices (as well as non-physicians who provide services under the physician fee schedule) would report data to CMS on the measures chosen by the physician or group from among those adopted and published by CMS.

- **Physicians would provide the Secretary with an attestation that the data will be submitted as required for reporting purposes.**

Setting forth this overall process in the legislation would ensure that it builds on existing structures that are in place to facilitate quality improvement programs and that have already completed significant work in this regard. As the AMA promised Congress last year, the Consortium has already developed about 100 quality measures and an additional nearly 70 are expected by the end of the year. Further, since the Chairman's proposal would provide a "ramp-up" period in 2007, the Consortium could use that time to develop measures similar to, but more cross-cutting than, those now contained in the proposal.

The AMA convened the Consortium in 2000 for the development of performance measurements and related quality activities. The Consortium is currently comprised of over 100 national medical specialty and state medical societies; the Council of Medical Specialty Societies, American Board of Medical Specialties and its member-boards; experts in methodology and data collection; the Agency for Healthcare Research and Quality; and Centers for Medicare & Medicaid Services. The Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance (NCQA) are also liaison members.

The Consortium is a physician-consensus-building organization and has become the leading physician-sponsored initiative in the country in developing physician-level performance measures. CMS is now using the measures developed by the Consortium in its large group practice demonstration project on pay-for-performance, and plans to use them in demonstration projects authorized by the MMA. Further, the Consortium has been working with Congress to improve quality measurement efforts, as well as with CMS to ensure that the measures and reporting mechanisms that could form the basis of a voluntary reporting program for physicians reflect the collaborative work already undertaken by the AMA, CMS, and the rest of the physician community.

A process that requires measures to be developed by physicians through the Consortium also ensures that measures are as cross-cutting as possible, thus expanding on the reporting options contained in the Chairman Barton proposal. This would provide all physician specialties with the opportunity to participate in any voluntary reporting program.

**A Physician Quality Improvement Program Should Be Voluntary, with Additional Payments to Offset Physicians' Administrative Costs in Reporting Data**

The AMA appreciates that Chairman Barton's proposal would implement a voluntary physician reporting program and provide additional bonus payments for meeting the reporting requirements. A voluntary program is especially critical since physician specialties are at varying levels of readiness with respect to the development of quality measures. Further, since the time dedicated to meeting the reporting requirements is an additional financial and paperwork burden on physicians, we also encourage Congress to provide bonus payments that fully offset physicians' administrative costs in meeting these. Without adequate offsets, the program simply becomes another unfunded mandate for physicians, which would undermine any incentive to participate in the program.

The Institute of Medicine, in its recently-released report, *Rewarding Provider Performance: Aligning Incentives in Medicare*, emphasized that a voluntary approach for physicians should be pursued initially, relying on financial incentives sufficient to ensure broad participation and recognizing that the initial set of measures and the pace of expansion of measure sets will need to be sensitive to the operational challenges faced by providers in small practice settings. The report also highlights the need for investment

dollars to create adequate resources to affect change due to the unique challenges of physician payment relating to the SGR, and further indicates that access could suffer if additional funds are not used to initiate a quality improvement program for physicians.

#### Medical Home Demonstration

**The AMA supports the concept of managing chronically ill Medicare patients under a “medical home” demonstration project, as is currently included Chairman Barton’s proposal. We urge that any such demonstration project apply to all physicians, not just primary care physicians.** Many other medical specialty physicians manage patients with chronic conditions, including such physicians as oncologists and cardiologists, and thus these other physicians should be permitted to participate in the medical home demonstration as well.

Under the Barton proposal, the Secretary would consider care management fees to the personal physician that covers the physician work that falls outside the face-to-face visit as a method of reimbursement under the medical home demonstration project. We note that there are existing CPT codes for care management. Thus, new codes for these services may not be needed.

#### Utilization Review

We appreciate that the utilization review provisions in Chairman Barton’s proposal would direct that such activities be carried out at the local level, where there is more ability to appropriately evaluate individual physician claims data and determine whether any changes in treatment protocol are necessary.

The AMA encourages, however, more specificity in the utilization review provisions to: (i) ensure that such programs are educational and not punitive — these programs should be for the purpose of providing physicians with utilization data to determine whether any changes to improve quality are needed in the treatment process; (ii) ensure that such programs protect the privacy of the claims data and do not allow such data to be discoverable in any legal proceeding against a physician; and (iii) allow aggregate data to be shared with appropriate medical specialty organizations.

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The AMA appreciates the opportunity to provide our views to the Subcommittee on these critical matters. We look forward to working with the Subcommittee and Congress to pass legislation immediately that preserves patient access, averts the 2007 physician pay cut, and provides a positive payment update that reflects medical practice cost increases.

MR. DEAL. Thank you.

Dr. Wolter, you are recognized.

DR. WOLTER. Thank you. And thank you, Chairman Deal and members of the committee for the opportunity to be here.

I have also been appreciating the opportunity to hear from my colleagues. I must say, finding so much agreement and common ground from 10 different physicians is a rare but enjoyable experience.

I am a pulmonary critical care physician and chief executive officer at the Billings Clinic in Montana. We are a 200-plus physician group practice, a 270-bed hospital, and we also operate a number of rural



physician clinics and manage seven critical access hospitals. We are one of 10 medical groups in the CMS physician group practice demo which is testing pay-for-performance in a very vigorous way looking at ways to both improve quality measures but at the same time reduce costs for the program.

I also serve as commissioner on the Medicare Payment Advisory Commission and am here today, though, as a member of the Board of Directors of the American Medical Group Association, which includes many large multispecialty groups around the country.

We very much applaud the committee's commitment to working on the problems facing us in terms of payment. The agreement about the sustainable growth rate flaws seems to be quite widespread. It is certainly neither controlling volume nor providing appropriate physician updates at this time.

Chairman Barton, Mr. Dingell and Chairmen Thomas and Johnson of the Ways and Means Committee have all developed proposals which are thoughtful in their attempt to deal with the SGR problem. We would support a blend of some elements of all of these proposals and certainly agree that the 3-year transition plan would be very helpful in terms of providing some stability while we look at longer-term solutions to redesign physician payment. And we do have some specific examples of thoughts of what might be included over those 3 years that we have included in our written testimony.

We also wanted to mention that, from our standpoint, the issue of reporting is critical. We really are hoping that Congress will work with the physician community and CMS to refine the CMS physician voluntary reporting program so that it will become usable for physicians and so that it can be done in a way that does not add tremendous expense and difficulty to physician practices.

We would also ask Congress to work with CMS to ensure that adequate capacity exists on the part of CMS to administer, collect, analyze and demonstrate quality data to PDRP participants. Participants in other CMS demonstrations have voiced some concern that CMS and its contractors at times have difficulty performing this function.

We are supporters of Chairman Barton's inclusion of structural measures in the qualifications for bonus payments. However, the process that might be done to arrive at those, physicians' use of structural measures, especially those related to health information technology and the use of allied health professionals are key components of how one can tackle improvements in cost and quality. So the structural measures in essence reflect the presence of infrastructure necessary to execute improvements.

On care coordination, we would like to say that SGR reform really is critical if we are going to move ahead with care coordination. Broader reforms over time to the entire delivery system may be needed, however, in particular structuring incentives for the provision of care coordination. Technology that can identify, enroll and create registries of patients with chronic illnesses is very critical, and creating a new reimbursement mechanism within CMS that pays for true coordinated care will, in our view, dramatically improve quality and also allow us to create significant cost savings.

Through the use of information technology and mid-level providers, for example, as part of our participation in the CMS demonstration project, we, over a recent 5-month period, managed to avoid 65 congestive heart failure admissions, saving the program approximately \$500,000. Those types of activities spread across the country would be a source of funding for some of the payment changes we need for physicians.

There is, in Chairman Barton's legislative language, a demonstration related to care coordination designed for primary care medical homes. This is a good first step. We also believe that Congress should look at legislation creating new care coordination reimbursement systems for physician groups that have already invested in appropriate infrastructure and are able to coordinate care for patients with high costs and complex illnesses.

The committee has spent much time looking at pay-for-performance systems. One of the things I have come to believe is that we might choose to have a bit more focus around the issue of pay-for-performance. For example, if we were to focus on four or five of the high-cost, high-volume chronic illnesses in this country, a significant improvement in quality and a significant amount of savings could be created with a little bit of focus.

The IOM said in its report on Crossing the Quality Chasm, that current care systems cannot do the job. Trying harder will not work. Changing systems of care will. Delivery system redesign will require greater cooperation between physicians and hospitals, a fact which both Congress and CMS recognize. Congress did require in the MMA a demonstration project examining the effects gain sharing may have on aligning financial incentives to enhance quality and efficiency of care. Recently, the recent MMA section 646 physician hospital collaborative demonstration is an example of this, and we think that these cooperative efforts between physicians and hospitals offer us great opportunity for both cost savings and quality.

In fact, in the report issued just last week by the Institute of Medicine, one of the recommendations is that, in the years ahead, goals

of new payment incentives should be to stimulate collaboration and shared accountability among providers across settings. The Institute of Medicine added that Congress should give HHS the authority to aggregate financing pools for different care settings into one consolidated pool from which all providers would be rewarded. These would be design elements in the years ahead and, of course, couldn't happen in the short run. Such cooperation and coordination, in my view, would lead to the type of integrated delivery systems and accountability care networks which could lead to significant improvements in cost and quality. Thank you.

[The prepared statement of Dr. Wolter follows:]

PREPARED STATEMENT OF DR. NICHOLAS WOLTER, CHIEF EXECUTIVE OFFICER, BILLINGS CLINIC, DIRECTOR, AMERICAN MEDICAL GROUP ASSOCIATION

### **SUSTAINABLE GROWTH RATE (SGR)**

#### **Physician Fees Cuts for 2007 and Beyond**

The underlying cause of the problem of physician fee cuts is the Sustainable Growth Rate (SGR) methodology, the basis used to determine physician fee schedule adjustments. While intercessions by Congress have ameliorated payments for doctors in the short term, they exacerbate the problem in the long term. Since the SGR target level is set to recapture cumulative overspending, excess spending is carried forward to be recovered in future years.

#### **Medicare Sustainable Growth Rate**

The Balanced Budget Act of 1997 (BBA) established the SGR methodology that sets yearly spending targets for physicians' services under Medicare. These SGR targets are intended to control the growth in aggregate Medicare expenditures for physicians' services. The fee schedule update is raised or lowered to echo the comparison of actual expenditures to target expenditures. If expenditures exceed the target, the update is reduced and conversely is raised if expenditures are less than the target.

Target expenditures for each year are equal to target expenditures from the previous year increased by the SGR, a percentage computed by combining estimates of the changes in each of four factors:

1. The estimated percentage change in fees for physicians' services
2. The estimated change in the average number of Medicare fee-for-service beneficiaries
3. The estimated 10-year average annual growth in real gross domestic product (GDP) per capita
4. The estimated change in expenditures due to changes in law or regulations

#### **Make the Methodology Better**

AMGA has long called for changes in the physician payment update system, including, among others, a call for eliminating SGR from the update calculation. Each one of the four data estimates used in the formula has been criticized for having insufficient, inaccurate, or irrelevant elements. The GDP imposes the volume and intensity spending target on the SGR, but the GDP has no relationship to physician services. A cost-based approach would be a more realistic and equitable basis to use.

The matter of volume control will still need to be addressed in an alternative to the SGR methodology. Criticisms of nationally applied volume controls such as the SGR method, fault the fact that it is too broadly based, an umbrella approach that is too unrefined for the purpose intended. It applies the same “fix” of payment reductions to all, irrespective of and causal linkage to the problems being addressed, significant medical services volume growth. One approach that has been suggested is the creation of geographically based volume control groupings as a means to address regional variations in medical service volumes. It has been postulated and to some extent demonstrated that there is no correlation between the increase in services and improved quality of care.

The Medicare Payment Advisory Commission (MedPAC), an independent body charged with making recommendations to Congress about Medicare, in its March 2006 Report, suggested implementing multiple SGR target pools, instead of the current, single national pool. While the AMGA does not favor continuation of the SGR, it could support the creation of methods that are not nationally applied to all, one that groups volume control methods in a more even handed and equitable way. In particular, we favor a multiplicity of groupings, one of which takes into account the effectiveness and efficiencies of highly organized and integrated delivery systems, a grouping that is based on membership in organized physician group practices or networks.

#### **Medical Group Practice Volume Proposal**

If Congress eliminates the SGR, but still requires a type of volume control mechanism for physician services, AMGA supports the idea of a separate volume control method using an aggregation for medical group practices. Some of the key concepts for such a pooling include:

- Being based on multi-specialty medical groups because of their systematic approach to integrating quality and technological improvements, their evaluation of patient outcomes, and their application of HIT.
- Criteria for participation would include:
  - Proof of a group’s accountability, organization, and commitment to evidence-based medicine and quality measurement/improvement, demonstration of an appropriate HIT infrastructure;
  - Participating groups would have their services aggregated into a collective group practice pool;
  - Continued participation would be dependent upon meeting performance standards; such as,
    - Broad application of health information technology (HIT);
    - Demonstration of a systematic approach to quality improvement
    - Development of coordinated care for beneficiaries with multiple chronic conditions;
- Appropriate risk adjustment factors for the patient population served should be developed and used to assure fairness and equity in computation of the pool.
- Design features need to assure correct matching, i.e. assignment of patients to the respective group practices;
- The pool would be designed to encompass participation beyond already existing medical groups, with incentives to encourage physicians to develop alliances with health plans, hospital medical staffs, and specialty group practices to meet the participation criteria;
- Savings realized in actual expenditures that fall below the target levels, should be shared with groups to provide incentives and reward success (this dovetails with emerging pay for performance focuses and might prove an effective alternative or supplementary approach for multi-specialty medical group practices).

### **Group Practices and System Redesign**

The seminal Institute of Medicine (IOM) report issued in 2001, *Crossing the Quality Chasm: A New Health System for the 21<sup>st</sup> Century*, broadly address medical care quality issues and provides strategic direction for improved, redesigned health care delivery in the U.S.

The IOM report enumerates six key challenges for the redesign of health care organizations. They are “redesigning care processes; making effective use of information technologies; managing clinical knowledge and skill; developing effective teams; coordinating care across patient conditions, services, and setting over time, and incorporating performance and outcome measurements for improvement and accountability<sup>1</sup>.

These systems attributes and characteristics are largely present in today’s AMGA members. There is a growing body of emerging evidence that suggests that medical practices embodying these systems produce a delivery system that is better able than small physician practices to make effective use of health information technology (including electronic medical records, patient registries, e-prescribing, etc.); is more likely to utilize evidence-based patient care processes; have physicians organized to practice in teams, collaborating with each other and non-physician health care givers; and use performance and outcome data with metrics for quality improvement; and for coordinating care among providers and settings<sup>2</sup>.

This body of evidence will likely be expanded as findings from several on-going Medicare demonstration projects on group practice and care coordination become known as the projects conclude. While yet in their early days, pay for performance systems may, as they evolve over time, also play evidentiary roles for systems redesign.

### **FOSTERING THE GROWTH, DEVELOPMENT AND CREATION OF MULTI-SPECIALTY MEDICAL GROUP PRACTICES**

AMGA believes that integrated delivery systems of health care are the most effective and efficient vehicle to provide the highest quality of medical services to Americans. The strongest underpinning of truly integrated delivery systems is the multi-specialty medical group practice model. The group practice model should be a significant national health care policy to stimulate formation, foster growth, and support development of multi-specialty group medical practices.

Multi-specialty medical group practices are often already the foundation of integrated delivery systems and when not, serve as the best underpinning for integrated health care delivery system formation. Doctors are the only professionals qualified to provide diagnosis and treatment of patients. As such they are the fundamental element, the core of medical care delivery. The most efficient mode of organization for their practices is the multi-specialty group medical practice and it should be the lynchpin of health care delivery in the United States.

### **Care Coordination**

In an effort to address the issues of cost and quality in the Medicare program, Congress has appropriately focused on transforming Medicare into a value-based purchaser of care. CMS announced the implementation of its Physician Voluntary Reporting Program and healthcare leaders in Congress have introduced a similar approach in “pay for performance” (P4P) legislation. These P4P efforts generally rely on provider adherence to clinical practice guidelines that apply to single diseases or health conditions.

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<sup>1</sup> Institute of Medicine, *op. cit.*, page 117.

<sup>2</sup> Crosson, Francis J. “The Delivery System Matters.” *Health Affairs* 24:6 (Nov/Dec 2005): 1543-1548.

While adherence to disease specific guidelines will decrease treatment variation for a particular disease and increase quality of care for some patients, this strategy fails to address the needs of a majority of Medicare patients, those with multiple chronic conditions. In 1999, almost half (48%) of Medicare patients aged 65 or older had at least 3 chronic conditions; more than twenty percent (21%) had 5 chronic conditions. Costs for treating these high service volume patients accounted for 89% of Medicare's annual budget. As the population ages, the number of chronically ill patients is expected to grow dramatically, with serious financial implications to the Medicare program.

Patients with chronic illnesses typically see multiple physicians and are prescribed multiple medications. Due largely to the complexity of treating these patients, health care for patients with chronic illnesses is often fragmented and poorly coordinated across providers and practice settings.

This lack of coordinated care has negative ramifications. According to a recent study, patients who reported seeing four or more physicians were three times as likely to report at least one type of adverse event (e.g., medicine, medication, or lab). Additionally, only 41 percent of U.S. patients who were taking more than 4 medications had a physician review their medication use during the past year, putting them at risk for adverse reactions. Not surprisingly, these complications increase the likelihood of hospital re-admissions, and additional office visits and procedures. Further, lack of coordination among providers can lead to costly inefficiencies such as duplicative testing, and unnecessary or inappropriate treatment.

In order to address the unique needs of patients with multiple chronic conditions, AMGA recommends that Congress broaden its approach beyond the current focus on single medical specialty/disease specific guidelines and measures to strategies that encourage the provision of coordinated care that emphasizes the necessary interdependency of primary care and specialty care.

In a *Veterans' Health Administration* clinical demonstration project that targeted high cost/use veterans and utilized care coordinators and home monitoring devices, ER visits were reduced by 40%, hospital admissions were reduced by 63%, and hospital bed days of care (BDOC) were reduced by 60%. Nursing home admissions were reduced by 64% and nursing home BDOC were reduced by 88%. Most importantly, quality of life indicators, as measured by patient survey responses, were significantly improved for participating veterans<sup>3</sup>.

AMGA has developed a Chronic Care Model that encourages care coordination across practice settings and disease conditions. AMGA's Model focuses on patient-centered care that includes: proactive daily monitoring of health status; reinforcement of self-care behaviors; early detection of problems and early intervention; and coordination of and collaboration among health care disciplines. Treating the "whole" patient is most successful when supported by innovative technologies including centralized electronic medical records, patient registries, and patient monitoring devices that allow the sharing of patient specific information when and where it is needed. Specifically, AMGA recommends incentives for providers that meet these performance measures:

- Structural Measures: EMR systems, patient registries, patient monitoring devices, professional care coordinator(s), integrated teams of primary and specialty care.
- Process Measures: Daily monitoring, case management, medication management, written (electronic or paper) feedback between primary and specialty physicians regarding treatment changes and referrals, multi-specialty treatment plans, patient self-management training.

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<sup>3</sup> Meyer, Kobb, Ryan, "Virtually Healthy: Chronic Disease Management in the Home", *Disease Management* 5:2 (2002).

- Outcomes Measures: Reduced hospitalizations, re-admissions, and BDOC, reduced nursing home admissions, re-admissions and BDOC, reduction in ER visits, patient satisfaction surveys, savings compared to Medicare FFS baseline.

This approach to caring for the chronically ill is fundamentally different than the traditional episodic care geared toward “fixing” patients when they develop a problem. Therefore chronic care requires a different definition of “quality” and a different approach to measurement. It calls for indicators of care coordination or “system-ness” that go beyond process measures for specific disease conditions.

AMGA believes the Model will provide patients with the best care, at the right time in the most appropriate setting. Moreover, the Model will produce significant cost savings due to decreased utilization and duplication of services.

AMGA recommends that Congress and CMS provide incentives to encourage coordinated care in the Medicare program.

#### **Physician Voluntary Reporting Program**

PVRP represents CMS’ interest in gathering clinical information that can be measured by evidence-based quality indicators. Collection and reporting of these measures will likely serve as part of the foundation of a new Medicare value-based purchasing system. Currently, participation by physicians is elective and involves the use of HCPCS G-codes, or as an alternative, submission of already existing data via the Doctor's Office Quality - Information Technology (DOQ-IT) program.

However, there are barriers inherent in both of these approaches that pose significant obstacles to participation for medical groups. Retooling sophisticated and often unique electronic capabilities to accommodate the keying of G-codes on each generated bill is prohibitively expensive and administratively burdensome. Furthermore, some systems are not currently capable of accommodating G-codes because their software vendor's systems do not handle “zero charges”. Also, other medical groups have had difficulty sharing medical records with non-affiliated institutions. Additionally, the DOQ-IT vehicle has too many limitations to make it a broadly available alternative. While technical capabilities may indeed exist, structural limitations caused by funding restrictions, make this approach “hit or miss”—depending on local QIO capacity.

Large multi-specialty group practices are quite different from other types of physician practices. They are, by and large, organized care delivery systems, and as such have built into their fabric an advanced model for performance measurement, quality control and continuous quality improvement. Some medical groups are fully integrated delivery systems and already participate in the Hospital Compare reporting program. Medical groups also participate in CMS demonstrations, as well as other projects focusing on quality and efficient care.

Medical groups provide integrated care, furnished by a team rather than by an individual physician. Within this kind of delivery system, multiple physicians, and other health care professionals, provide care that crosses traditional specialty lines and settings.

Medical groups often have in place internal systemic quality controls, based on continuous peer review and EMRs and other infrastructural support systems. Such medical groups perform as a single entity and therefore should be measured as a single entity. They are large enough for sampling to provide sufficiently robust data to measure quality. They also have a proven track record as efficient providers of care and have existing mechanisms to distribute data and rewards.

Given these differences, AMGA proposes that CMS permit medical groups to collect and submit quality data in the form of periodic, aggregate reporting, rather than through individual billings. This allows medical groups to provide complete data, dramatically reduce physician administrative work and reduce information technology expenses.

The proposal builds upon the strengths of the medical group model and also fulfills CMS' goals for PVRP:

- capturing and reporting on quality data;
- increasing physician participation in PVRP;
- encourage the use of health information technology (HIT), particularly, electronic medical record systems (EMR).

#### **Promoting Effective Use of Health Information Technology (HIT)**

Increased adoption and implementation of HIT, which can range from electronic patient registries to sophisticated electronic medical record systems (EMRs), has the potential to increase quality and decrease costs.

Because HIT has the potential to dramatically improve the quality and safety of patient care, some hospitals and medical groups with sophisticated HIT systems are ready to begin exchanging clinical data with community physicians. While many hospitals and medical groups already have web portals that allow physicians access to patient data, there is little two-way exchange of data. Therefore, these providers would like to assist physicians to take the next step and adopt EMRs.

Increased physician adoption of HIT begins to create a culture of use and reliance on sophisticated HIT systems, easing the transition to a wholly electronic system in the future. Of course, not all hospitals and medical groups are in a position to help physicians adopt EMRs, but those that would like to cannot, due to, in large part, to the Stark and AKB laws.

These arrangements implicate the Stark and AKB laws and, because of the draconian sanctions associated with these laws, providers have been reluctant to enter into these arrangements. Notably, in an August 13, 2004 report on barriers to HIT, the General Accountability Office (GAO) stated that Stark and AKB "present barriers by impeding the establishment of arrangements between providers-such as the provision of IT resources-that otherwise promote the adoption of IT." Additionally, the Office of the National Coordinator for Health Information Technology (ONCHIT) stated that these fraud and abuse statutes pose barriers to greater HIT adoption.

AMGA members have pioneered the use and application of HIT in their practices and have, by and large, made significant investments in this important infrastructural element both as a practical matter and for philosophical reasons. Appropriate incentives will have to be forthcoming to advance broad adoption and implementation of HIT to realize its potential for reducing medical errors, improving patient safety, enhancing care coordination, etc. However, any financial support, direct or indirect, that may evolve over time, must take into consideration the investments and leadership demonstrated by those entities, including many AMGA members, by recognizing and repaying them for having had the vision to install and apply HIT.

#### **Conclusion**

The SGR "fix" is a critical focus for the short term to avert the dire consequences of the impending 5.1% physician fee schedule negative update and for the longer term to address the projected cuts for the next years. If left unchecked, there is a high likelihood that access to care for Medicare patients may become increasingly difficult. This fatally flawed methodology must be abolished.

In addition much broader health delivery system redesign is necessary, particularly in the realignment of incentives to assure progress in the attainment of national health care policy objectives such as, delivery of efficient, high quality health care, and coordination of care, particularly for those with chronic diseases. The specifics enumerated in this testimony are all steps in the right direction.

The body of evidence is growing that multi-specialty group medical practices are a delivery mode that offers many advantages and benefits. Many of the national policy



goals are already being undertaken and realized by AMGA's members. It is time for Congress to recognize the value and importance of this delivery model and to take legislative action to foster creation, development and growth of multi-specialty medical group practices.

Should you have questions or wish additional information, please contact Chet Speed, J.D., L.L.M., Vice President of Public Policy, American Medical Group Association, at [cspeed@amga.org](mailto:cspeed@amga.org), or (703) 838-0033, extension 364.

MR. DEAL. Thank you.

Dr. Thames.

DR. THAMES. Mr. Chairman, members of the committee, I am Dr. Byron Thames, a member of the Board of Directors of AARP, and thank you very much for asking me--inviting me to testify today.

Medicare and the millions of beneficiaries who rely on it should get more for their health care dollar. Medicare now pays nothing more to recognize physicians who give beneficiaries high-quality care. Instead, Medicare sometimes pays more to those who provide poor quality care by reimbursing for services that are inefficient.

Rather than addressing the underlying issue of paying for good quality, short-term SGR fixes have been limited to annual payment increases that simply shift costs on to beneficiaries. As a result, increased Part B premiums erode Social Security COLAs. Higher coinsurance further limits retirement income and the quality of care does not improve.

AARP believes there must be a comprehensive approach to Part B payments that protects beneficiaries from unreasonable premium coinsurance and balance billing increases and aligns incentives to encourage high-quality care.

Tying Medicare's payment to the quality of the care provided is a reasonable way to achieve that goal. Paying providers to simply report quality data may be a necessary first step in this effort, but it cannot be the only step. Congressional efforts to address physician payment concerns this year should, at the very least, make payment increases contingent upon reporting of quality data. Eventually, payment updates should be provided to those physicians who meet gradually increasing requirements for both reporting data and demonstrating quality improvements.

America already spends more per capita on health care than any other nation, but clearly we are not getting our money's worth. Researchers at Dartmouth Medical School estimate that Medicare could reduce spending by at least 30 percent while improving the medical care of the most severely ill Americans if the practices of low-cost, high-quality providers were followed nationwide.

A well structured pay-for-performance approach could promote the use of these best practices. In the long run, pay-for-performance also

may help control spiraling health care costs. It could reduce costly errors, avoid unnecessary service duplication, and lessen improper utilization. Congress should seize this opportunity to forge a truly sustainable Part B payment system by moving towards a pay-for-performance system that realigns payment with high performance and protects beneficiaries from unnecessary costs.

Thank you very much, Mr. Chairman.

[The prepared statement of Dr. Thames follows:]

PREPARED STATEMENT OF DR. BYRON THAMES, BOARD MEMBER, AARP

Mr. Chairman and members of the committee, my name is Byron Thames. I am a physician and a member of AARP's Board of Directors. Thank you for inviting AARP to testify on the important topic of Medicare physician payments.

Over 41 million Americans rely on Medicare for their health insurance. Changes in how Medicare pays physicians have a direct impact on whether we continue to keep this program affordable for beneficiaries.

Unfortunately, recent short-term measures to address the SGR issue have been limited to annual payment increases that simply shift more out-of-pocket costs to beneficiaries without any material improvements in the quality of care they receive. AARP believes there must be a comprehensive approach to Part B payments that not only protects beneficiaries from unreasonable premium and coinsurance increases, but also aligns incentives to encourage high quality care. Medicare and beneficiaries should be getting more for their health care dollar. Tying Medicare's payment to the quality of the care provided is a reasonable way to achieve that goal.

**Short Term "Fixes"- No Bargain for Beneficiaries or Medicare**

The recent announcement that the 2007 Medicare Part B monthly premium of \$93.50 (a 5.6 percent increase from the current \$88.50 premium) is lower than originally projected is better than expected. But the calculations for the 2007 premium assume that Medicare physician spending will be cut by 5.1 percent next year as called for under the current payment formula. If Congress acts this year to prevent the physician cut – as many assume – the added cost will further increase the Part B premium. Since the 2007 premium has already been calculated, these increased costs will be rolled into the 2008 – and possibly 2009 – Part B premium. That means that beneficiaries can expect even higher Part B premiums in 2008 and beyond.

The increase in the 2007 premium comes on the heels of a 13.2 percent increase in 2006, a 17.4 percent increase in 2005 and a 13.5 percent increase in 2004. In each year, the premium increase significantly eroded or eliminated the Social Security COLA for beneficiaries with lower or moderate incomes. (See chart 1). These increased costs also erode some of the savings that beneficiaries were to realize from the new Medicare Part D drug coverage.

Increased costs to beneficiaries are not limited to premiums. Cost-sharing obligations – which usually reflect 20 percent of Medicare's payment – also jump each time provider reimbursement rates increase.

The impact of the premium and cost-sharing increases cannot be ignored. The average older person already spends about one quarter of his/her income on health care. That does *not* include the additional, and often substantial, costs of services that Medicare does not cover – including long term home and nursing home care. If Part B premiums and cost-sharing continue to escalate, many beneficiaries will find it increasingly difficult to pay for the care they need.

Further, Congress should also recall that every Part B reimbursement increase accelerates the Medicare “trigger”. Enacted in the Medicare Modernization Act, the trigger requires Congress to consider potentially harmful cost containment action when the Medicare Trustees project for two consecutive years that general revenues will account for more than 45 percent of total program costs in the next seven program years. Increasing provider payments – without rationalizing the payment system – only contributes to the trigger. (See chart 2).

AARP urges Members of Congress to improve the Part B payment system in a way that protects beneficiaries from unreasonable increases in the Part B premium and coinsurance. This is necessary to ensure that health care does not continue to become increasingly unaffordable for Medicare beneficiaries over time.

### **Making Medicare a Better Payer of Quality Care**

AARP believes that Medicare’s Part B payment system should include incentives to promote high quality care. Paying providers to simply *report* quality data may be a necessary first step in this effort, but it cannot be the only step.

Medicare now pays nothing more to recognize those physicians and other providers who give beneficiaries high quality care. Instead, Medicare sometimes pays more to those who provide poor quality care by reimbursing for services that are inefficient or needed to treat the harm resulting from preventable medical errors.

Congressional efforts to address physician payment concerns this year should, at the very least, make payment increases contingent upon reporting of quality data. Eventually, payment updates should be provided to those physicians who meet gradually increasing requirements for both reporting data and demonstrating quality improvements.

It simply makes no sense to continue giving providers higher payment rates that are not linked to quality improvement. America already spends more per capita on health care than any other nation, but clearly, we are not getting our money’s worth.

Researchers at the Dartmouth Medical School have documented that regions of the United States with the highest health care spending do not have sicker patients or better outcomes than regions with lower spending. They estimate that Medicare could reduce spending by at least 30 percent, while improving the medical care of the most severely ill Americans, if the practices of low-cost, high-quality providers were followed nationwide. A well-structured pay for performance approach could promote the use of those best practices.

The time has come to improve our approach to paying Medicare providers. Offering rewards for high quality, quality improvement, and use of health information technology (HIT) simply makes good business sense.

In the long-run, pay for performance also may help control spiraling health care costs. It could reduce costly errors, avoid unnecessary service duplication, and lessen improper utilization.

Pay for performance might further help temper the tendency to increase the volume of services billed to Medicare following any limits on growth in reimbursement rates. This well-documented volume increase is arguably a greater health threat than the oft-predicted but rarely seen specter of physicians refusing to see Medicare patients if rates do not continue to rise. The Government Accountability Office and MedPAC report that nationwide beneficiaries are not reporting increased difficulties in finding a physician. In fact, the number of services provided, the number of physicians billing Medicare, and the number of physicians accepting Medicare fees as payment in full have all risen.

This volume adjustment phenomenon poses a real health threat because it suggests that Medicare beneficiaries may be receiving many unnecessary services. Increased volume also threatens the financial health of Medicare and of beneficiaries charged coinsurance for unnecessary services. And it is among the reasons why the current

physician reimbursement formula, which takes volume into account, repeatedly results in potential pay cuts.

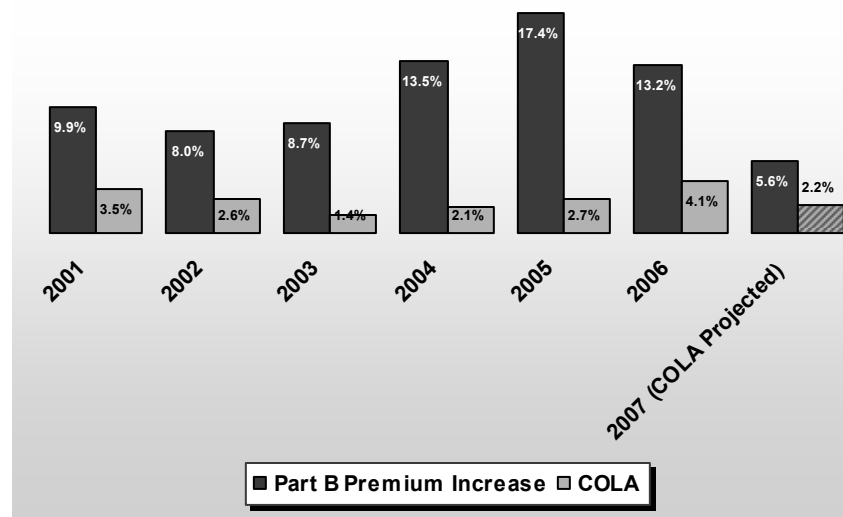
### Conclusion

While the repeated threat of physician cuts resulting from the current formula may seem like a crisis, it is in fact an opportunity. Congress should seize this opportunity to forge a truly sustainable Part B payment system by moving towards a pay-for-performance system that realigns payment with high performance. This new system should also be designed with the beneficiary in mind by holding cost-sharing and premium increases down and improving the quality of care beneficiaries receive.

AARP looks forward to working with Members of the Committee to seize this opportunity and advance quality health care.

**Chart 1**

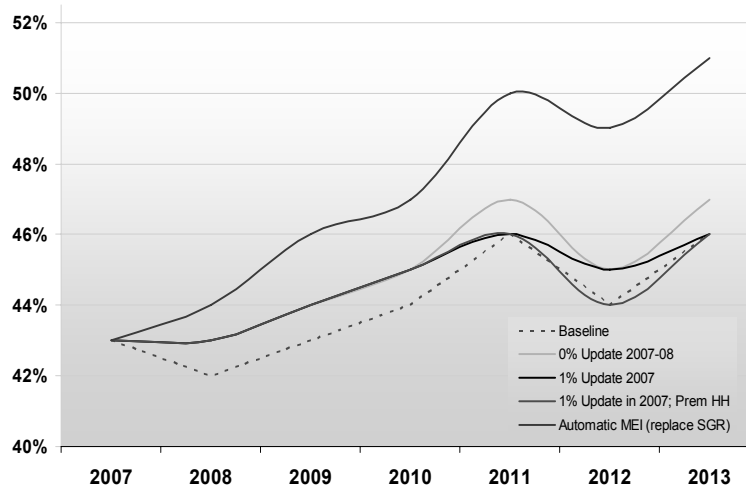
**Percent Increase in Part B Premium Dwarfs  
Social Security Adjustments**



Source: Premiums: 2006 Medicare Trustees Report; 2007: CMS Sept. 12 Press Release  
COLA: [www.ssa.gov/OACT/COLA](http://www.ssa.gov/OACT/COLA)

Chart 2

### Changes to the "Trigger" as a Result of Increasing the Physician Update – Selected Options



Source: AARP Analysis based on CBO Estimates of Changes to the Physician SGR

AARP Federal Affairs  
July 24, 2006

MR. DEAL. Thank you.

Dr. Cook you are recognized.

DR. COOK. Good afternoon, Chairman Deal, and distinguished members of the subcommittee.

My name is Dr. Sallie Cook, and I serve as the President of the American Health Quality Association, AHQA. AHQA is the national association representing quality improvement organizations, QIOs, working to improve health care quality in communities across America. I am also the chief medical officer of the Virginia Health Quality Center, Virginia's QIO. Thank you for the opportunity to provide testimony about the QIO program.

H.R. 5866 outlines a vision for a stronger QIO program, and we commend the superb leadership of Congressman Burgess and the bipartisan roster of now 36 cosponsors of this bill. Health care quality is not what it should be. Americans get only about half of the recommended care they should for their condition, and more patients die each year from medical errors than from car accidents. The cost of health care keeps rising. Patients, providers, payers--none of them are

satisfied. These outcomes are rarely the fault of individual health care providers but arise from unsafe systems of care.

QIOs have experts in every State who work with hospitals, doctors, nursing homes, home health agencies and others to improve patient care. Under our performance-based contracts with Medicare, QIOs work collaboratively with physicians and other health care providers to redesign systems of care so that every patient receives the right care every time.

Health care quality does not improve by itself. It takes hard work. Physicians, nurses and others work hard every day and benefit from our expert help identifying quality gaps and learning how to close those gaps.

As an example, my written testimony includes an anecdote and data from the Gordon Health Care Nursing Home in your district, Mr. Chairman, eliminating the use of physical restraints in their facility, thanks to the work of the Georgia QIO. This March, in a report requested by Congress, the Institute of Medicine said that the country's QIOs must play an integral role in the Federal Performance Improvement Initiatives. The QIO provisions in Title II of Congressman Burgess's bill would enact most of the recommendations made in the IOM's report on QIOs. The bill would modernize the law by requiring that QIOs help providers in all settings to redesign their systems of care, adopt health information technology, decrease health disparities and submit data on valid measures of quality that can be used for reporting and incentive programs.

QIOs do these things today, and the bill will bring the law up to speed with current efforts. For example, right now, QIOs are helping more than 4,000 small- and medium-sized primary care practices to adopt health IT and to use it to improve care. In this way, we are helping doctors improve care as well as helping to build the data collection infrastructure needed for quality measurement and pay-for-performance.

H.R. 5866 would also improve the way QIOs handle complaints from Medicare beneficiaries about quality of care. Congress entrusted this important function to us in 1986, and many QIOs have now integrated their quality improvement methods into the way they respond to complaints. However, the law must permit QIOs to make the complaint process more transparent for beneficiaries. Dr. Burgess's legislation does that.

We also support the QIO governance reforms in this bill. Any organization entrusted with the work of serving Medicare beneficiaries and health care providers must be held to high standards of accountability. Every nonprofit member of AHQA has adopted the association's high standards for organizational integrity.

We also support provisions to increase contractor competition and improving quality under Medicaid. In its August report to Congress on the QIO program, Health and Human Services Secretary Michael Leavitt said, "The QIO program has the potential to make a substantial contribution to the efficiency of resource use in Medicare." We agree with that vision. The QIOs can collaborate with physician stakeholder organizations to share efficiency and quality data with physicians.

For those with quality and cost data that is outside the norms of their peer group, these physicians could work voluntarily with the QIO to implement efficient, high-quality processes in areas where there is reliable data and its accepted treatment guidelines. We know from public reports that the QIO program is making a critical difference in the lives of America's seniors. The latest article appeared 2 weeks ago in the *Annals of Internal Medicine*. It shows intensive efforts by QIOs led to nationwide improvements in the quality of health care in a wide variety of settings. In 18 of the 20 measures studied, great improvement was observed among providers working closely with the QIO.

Medicare is getting a good value for its investment in QIOs, which amounts to less than one-tenth of 1 percent of Medicare spending. The quality improvement budget of this successful program has been shrinking both in relative and absolute terms, but we are working hard with Medicare's investment to produce substantial returns in quality and efficiency, and we will do much more with additional resources.

On behalf of the QIO community, thank you for your thoughtful deliberation on the future of this important program.

[The prepared statement of Dr. Cook follows:]

PREPARED STATEMENT OF DR. SALLIE S. COOK, PRESIDENT, AMERICAN HEALTH QUALITY ASSOCIATION, CHIEF MEDICAL OFFICER, VIRGINIA HEALTH QUALITY CENTER

Good afternoon Chairman Deal, Ranking Member Brown and distinguished members of the Subcommittee. My name is Dr. Sallie Cook, and I serve as the President of the American Health Quality Association (AHQA). AHQA is the national association representing Quality Improvement Organizations (QIOs) and professionals working to improve health care quality in communities across America. I am also Chief Medical Officer of the Virginia Health Quality Center, the Medicare QIO for the Commonwealth of Virginia. Thank you for this opportunity to provide testimony about the QIO program and ways to strengthen this important national infrastructure.

The Medicare Physician Payment Reform and Quality Improvement Act of 2006, HR 5866, outlines a vision for a stronger QIO program, and we commend the superb leadership of Congressman Burgess and the bipartisan roster of 33 cosponsors of this bill. As we all know, health care quality is not what it should be -- Americans get only about half of the recommended care for their condition and more patients die each year from medical errors than from car accidents. All the while, the cost of health care keeps rising. Neither patients, nor providers, nor payers are satisfied. These outcomes are rarely the fault of individual health care providers, but mostly arise from unsafe systems of care.

QIOs are community-based experts in every state and territory who work with hospitals, doctors, nursing homes, home health agencies, pharmacies and health plans to improve patient care. Under our performance-based contracts with Medicare, QIOs work collaboratively with health care providers to redesign systems of care so that every patient receives the right care every time.

Health care quality does not improve by itself – it takes hard work. Physicians, nurses, and others are working hard every day, and these professionals benefit from our expert help identifying quality gaps, and learning how to close those gaps. QIOs offer the only nationwide field force of experts dedicated to understanding the latest strategies in quality improvement and working with health professionals at the local level to make good care better.

As an example of some of the great partnerships between QIOs and providers, I'd like to relay to you a story, Mr. Chairman, from your 10th district of Georgia. There, the Georgia Medical Care Foundation, the QIO for the state, has been working with dozens of local providers, including the Gordon Health Care nursing home in Calhoun. Together, the QIO and Gordon have reduced the number of residents in physical restraints from 11% of residents in 2004 to zero. Dawn Davis, Gordon's director of nursing, credited help from the QIO for the success, saying GMCF provided facility staff with "much needed information" and training on the dangers of restraints and potential alternatives. Ms. Davis reports that the facility is now restraint free, and plans to keep it that way.

This March, in a report requested by Congress, the Institute of Medicine said that the country's QIOs should play an integral role in federal performance improvement initiatives like the work I just described, and recommended modernization of the program to fully realize its potential. The QIO provisions in Title II of Congressman Burgess' bill would enact most of the recommendations made in the IOM's report on QIOs. The bill would modernize the law by requiring that QIOs help providers in all settings to redesign their systems of care, adopt health information technology, decrease health disparities, and submit data on valid measures of quality that can be used for reporting and incentive programs.

QIOs do these things today and the bill will bring the law up to speed with current efforts. For example, right now QIOs are helping more than 4,000 small and medium-sized primary care practices to adopt health IT and use it to improve care. Many of these practices treat higher proportions of underserved patients. In this way, we're helping doctors improve care, as well as helping build the data collection infrastructure needed for quality measurement and pay for performance.

HR 5866 would also improve the way QIOs handle complaints from Medicare beneficiaries about quality of care. Congress entrusted this important function to us in 1986, and many QIOs have now integrated their quality improvement methods into the way they respond to complaints. However, regulations have lagged behind today's understanding of effective quality improvement. Congress must reform this process to make it more patient-centered. The law must permit QIOs to make the complaint process more transparent for beneficiaries. Dr. Burgess' legislation does that.

We also support the QIO governance reforms in this bill. Any organization entrusted with the work of serving Medicare beneficiaries and health care providers must be held to high standards of accountability. Every nonprofit member of AHQA has adopted the Association's high standards for organizational integrity. We also support provisions to increase contractor competition and improving quality under Medicaid.

We encourage the Subcommittee to utilize the QIOs to help improve the efficiency of health care by directing them to focus on efficiency measures which, we believe, should be based on the cost of providing high quality care. QIOs already share quality data with providers and work with them to improve. The same could be done with efficiency data, especially if coupled with data on clinical quality.



In his August Report to Congress on the QIO program, Health and Human Services Secretary Michael Leavitt said: “The QIO program has the potential to make a substantial contribution to efficiency of resource use in Medicare.” We agree with that vision. The QIOs can collaborate with physician stakeholder organizations, particularly state medical societies, to share efficiency and quality data with physicians. For those with quality and cost data that is outside the norms of their peer group, these physicians could work voluntarily with the QIO to implement efficient, high quality processes in areas where there is reliable data and accepted treatment guidelines. For example, QIOs could coordinate exchange visits that convene doctors to share effective change methods.

Another efficiency topic we are already working on is preventing avoidable hospital admissions among patients receiving home care. In just a little more than a year, by partnering with home health agencies, this QIO initiative has already saved Medicare approximately \$130 million in reduced unnecessary hospital admissions.

We know from published reports, summarized in an attachment to my written testimony, that the QIO program is making a critical difference in the lives of America’s seniors. The latest article appeared just two weeks ago in the *Annals of Internal Medicine*. It showed intensive efforts by the QIOs led to nationwide improvements in the quality of health care in a wide variety of settings. In 18 of the 20 measures studied, greater improvement was observed among providers working closely with the QIO.

This and other studies show that Medicare is getting good value for its investment in QIOs, which currently amounts to less than one-tenth of one percent of Medicare spending. We are troubled that the quality improvement budget of this successful program has been shrinking both in relative and absolute terms. But we are working hard with Medicare’s investment to produce substantial returns in quality and efficiency, and we will do much more with additional resources.

On behalf of the QIO community, thank you for your thoughtful deliberation on the future of this important program.

### **Closing the Quality Gap**

Published evidence continues to mount documenting the positive impact QIOs are having on improving patient care in America. In addition to the strong endorsement from the distinguished IOM panel in their March report, the value of the QIO program was recently extolled by Secretary Leavitt in his August report to Congress in response to the IOM’s report.

The Secretary’s report characterized the QIO program as “a cornerstone [of CMS] efforts to improve quality and efficiency of care for Medicare beneficiaries,” saying that “The Program has been instrumental in advancing national efforts to measure and improve quality, and it presents unique opportunities to support improvements in care in the future.” Many of the Secretary’s recommendations are aligned with HR 5866.

And those who directly benefit from our help also say that our impact on patient care is positive and strong. A January independent study confirmed that these stakeholders are deriving tremendous value from the services provided by the QIOs. The study found that three out of four stakeholders agreed that “providers are providing better care because of QIOs.”

Among other results, the survey showed that:

- 91% found the information and assistance provided by their QIO valuable.
- 90% were satisfied with all interactions and partnerships with their QIO.
- Of those respondents who have an “on-going partnership” with their QIO – nearly all (98%) reported being satisfied with QIO efforts, including 84% who were very satisfied.

Survey respondents included a broad cross-section of key stakeholders, including members of several of the organizations testifying before the Subcommittee today,

including the American Academy of Family Physicians, American College of Physicians, and the American Medical Association. The survey findings are a strong endorsement of the QIO contribution at the front lines of the effort to improve health care quality, and further confirm that QIOs are making health care better.

Additional data was released earlier this month documenting the impact of the QIO program during the most recent three-year period of performance, from 2002-2005. According to a study in the September 5 *Annals of Internal Medicine*, intensive efforts by the nation's QIOs likely led to nationwide improvements in the quality of health care in a wide variety of settings. And care tended to improve more among providers working with QIOs.

The study, conducted by federal researchers, assessed improvement in care in areas such as diabetes management, appropriate heart failure treatment, and pain management in nursing home residents. QIOs worked intensively with a subset of health care providers in physician offices, nursing homes, and home health agencies. These providers achieved greater improvement on 18 of 20 clinical quality measures than providers that did not work intensively with a QIO, including significant progress among nursing homes and home health agencies—two new areas of QIO work that began nationwide in 2002. Among the most significant findings:

- Nursing homes working with QIOs improved on all five measures studied – while those working intensively with a QIO improved to the greatest degree. For example, QIOs and nursing homes working most closely together halved the number of nursing home residents in chronic pain (from 13% of residents to 6.2%), and halved the percentage of nursing home residents who were restrained (reduced from 16.5% to 8.4%).
- Home health providers working with QIOs improved to a greater extent than providers not working with QIOs on eight of 11 clinical quality measures. Those working most closely with the QIOs improved to a greater extent than other agencies on all 11 measures.
- Physician offices working with QIOs improved in all four measures studied, and improved by greater amounts than offices that did not work with the QIOs. The greatest improvement was seen in the quality of care for patients with diabetes. Timely blood sugar testing improved by about 9% and timely lipid profile testing improved by about 11%. QIOs working more intensively with physician practices were able to reverse two apparent trends. These practices increased the number of women receiving timely mammograms and the number of patients with diabetes receiving a key retinal eye exam. Practices not working with their QIO saw decreases in these two measures.
- Hospital care improved in 19 of 21 measures studied. The study could not compare hospitals that worked with QIOs with those who did not because QIOs were asked to help hospital providers throughout their state to improve. However, substantial improvement in surgical infection prevention occurred at a time preceding the adoption of surgical infection measures by the JCAHO and public reporting of hospital performance on these measures.

The findings underscore other recent research showing how QIO assistance helps providers improve care they deliver to Medicare beneficiaries. The 2005 *National Healthcare Quality Report*, released by the Agency for Healthcare Research and Quality earlier this year, found that QIO measures for heart disease and pneumonia showed a combined rate of improvement that was almost four times higher than all other non-QIO measures. The *American Journal of Surgery* last year published a report on a national QIO project involving 43 hospitals that reduced their post-surgical infection rate by 27% with QIO assistance.

All of these studies are consistent with our experience that when QIOs and providers work together, the quality of care improves faster. Of course, much of the credit for these improvements goes to providers who are willing to change and work with QIOs to improve patient care.

### **Pay for Performance**

Last week, in its highly anticipated report on pay for performance, the IOM called for a phased-in national pay for performance program that will provide financial incentives for care that is safe, effective, timely, patient-centered, efficient, and equitable. In its report, the IOM said QIOs offer an “important national resource in building the necessary infrastructure” for the technical assistance that providers need to qualify for payment incentives. “Technical assistance for quality improvement will become increasingly important throughout Medicare as pressure to contain health care costs grows, and providers place more emphasis on quality improvement with the expansion of pay for performance programs,” the IOM said.

We support payment to reward high levels of quality and improvements in quality. But the IOM is right to say that payment rewards alone won’t get the job done, and that quality improvement technical assistance through the QIO program should be available to more providers to help them succeed. These recommendations would become law if HR 5866 is enacted.

We also encourage Congress to utilize QIOs as an independent national feedback mechanism for the “active learning system” that the IOM recommended in its payment for performance report. QIOs can report back to federal agencies on consumer, employer, and provider perceptions regarding federal transparency initiatives. QIOs serve as expert feet on the ground and could alert these agencies to measurement problems and unintended consequences of pay for performance efforts – such as decreased patient access. Feedback from consumers and stakeholders is essential in developing a sustainable program to meet the needs of the public and the providers. QIOs are a uniquely qualified national infrastructure with both the strong local relationships and the expertise needed to help the Secretary continuously improve this program.

The primary role for QIOs in pay-for-performance is to support local providers through technical assistance and the provision of evidence-based guidelines. We agree with the IOM’s finding that QIO assistance must be a central part of future performance improvement initiatives because it reflects our experience that success in quality improvement happens faster when doctors work in partnership with experts who understand cutting-edge improvement techniques.

### **Helping Physicians Adopt Health Information Technology**

There is great interest in Congress and the administration in promoting health information technology as a tool for improving care and supporting data collection. And we know that many barriers stand in the way of widespread adoption among physician practices. Chief among these barriers is of course a real and perceived financial burden.

While financial help is of paramount importance, our experience tells us that even free equipment and software is unlikely to improve quality on its own. The promise of HIT lies not in simply automating current practices, but in transforming them. To achieve transformation, physicians need help from local experts to guide them through the process of preparing and planning, selecting a product and vendor, redesigning their clinical operations and then using their new system to improve care. These are daunting tasks for busy clinicians who cannot stop seeing patients.

Literature and experience tell us that as many as half of all IT implementations fail for one reason or another, often because practices did not go through the rigorous

preparation and development necessary for success. QIOs across the country are helping physicians protect the value of their investments by providing this help at no cost.

In Utah, for example, one clinic had been using their EHR system for seven years, but had never turned on the clinical decision support or disease management functions because using those functions on a regular basis simply did not fit into their daily workflow. The clinic asked their QIO, HealthInsight, for help. HealthInsight showed the clinic how to evaluate their existing workflow and redesign their care processes so that the practice could utilize these high-level functions of their IT equipment – functions which are central to improving quality.

Despite the fact that QIOs don't subsidize physician purchase of HIT or implement these systems, in just one year, 4,308 practices signed up for assistance from their local QIO, including 1,162 practices that treat higher proportions of underserved patients. Of the total number of practices we are working with, nearly three quarters have just one to three physicians, while the remaining quarter practice in groups of four to eight physicians. These are exactly the kind of practices that most need help – those who cannot afford to buy the kind of expert consultants that can have a tremendous impact on the cost and effectiveness of the IT adoption and implementation process. As Congress considers two very important health IT bills, we hope you will expand the availability of this assistance.

### **Helping the frail and elderly**

#### *Nursing Homes*

As part of the CMS National Nursing Home Quality Initiative (NHQI), QIOs have been assisting long-term care facilities on a national basis since 2002. QIOs educate nursing home staff on the principles of quality improvement with guideline-based clinical training that is relevant to publicly-reported measures. QIOs work with all nursing homes throughout their states to set quality improvement targets for certain measures on an annual basis.

Historically, most nursing homes have focused on compliance with regulations and quality assurance. But the impetus of public reporting and the availability of QIOs for technical assistance on these measures have resulted in more nursing homes developing a quality improvement approach to improving resident outcomes and quality of life. Across the country, QIOs are training nursing home managers to implement quality improvement systems in a culture where front line staff not only participate in quality improvement projects, but also are empowered to continually identify and solve problems.

QIOs also work with a group of nursing homes to collect information on resident and staff satisfaction and assist these nursing homes to decrease staff turnover. QIO staff train nursing home administrators and directors of nursing to promote a culture of quality improvement in their facilities.

Although this work is relatively new, our partnerships with nursing homes and other long-term care stakeholders have already produced remarkable progress nationwide. According to the *Annals* article, nursing homes working intensively with a QIO improved more on all five measures studied. For example, QIOs and nursing homes cut in half both the number of nursing home residents in chronic pain and the percentage of nursing home residents who were restrained.

QIO assistance for nursing homes is coordinated with the quality improvement efforts of the federal government and the nursing home industry, such as the new provider-driven, national quality campaign called Advancing Excellence in America's Nursing Homes, which is scheduled to kick off at a summit meeting tomorrow.

### *Home Health*

QIOs also are working to accelerate the pace of quality improvement among patients receiving care in their own home. In particular, QIOs are partnering with home health agencies (HHAs) to reduce acute care hospitalizations, promote the adoption of telehealth systems, increase immunization screenings during patient assessments, and evaluate and improve HHAs' organizational culture.

Since 2002, thousands of HHAs have formed effective partnerships with their local QIO and committed to improving care on publicly-reported home health quality measures using the Outcomes-Based Quality Improvement process. This has been a fruitful relationship that is achieving better quality care for patients receiving treatment at home. For example, according to the *Annals* article, home health providers working with QIOs improved to a greater extent than providers not working with QIOs on 8 of 11 clinical quality measures. Those working most closely with the QIOs improved to a greater extent than other agencies on all 11 measures.

But there are opportunities for even greater advancement, and QIOs are now working with home health agencies and other community health care stakeholders—including hospitals, consumers, physicians, survey agencies, nursing homes, and others—to help prevent avoidable hospitalizations. Currently, 28% of all home care episodes end in an acute care hospitalization—with more than 3.6 million home health episodes each year, that means there are more than 1 million hospitalizations. While many sick patients need to utilize hospital services, research indicates that there are best practices, such as effective hospital discharge planning, better medication administration, improved communication, and the use of telehealth services that are effective in preventing the exacerbation of patient's conditions and therefore preventing an unnecessary hospitalization. Furthermore, a recent report on hospitalizations among home health patients found that a 3% reduction in the national hospitalization rate could save \$1.2 billion. As noted above, QIO efforts to reduce avoidable hospitalizations by working with home health agencies have made a substantial down payment toward these potential savings.

In addition, QIOs are helping home care agencies ensure that America's seniors receive their influenza and pneumococcal immunizations. Health care providers and stakeholders have a shared responsibility to ensure that vulnerable elders are immunized, and the QIOs are ready to help incorporate immunization screening into comprehensive patient assessments and deliver vaccinations safely. QIOs also are working with agencies to utilize home telehealth technology to improve the effectiveness and efficiency of home care. QIOs have information and tools about telehealth that agencies can use to reduce hospitalizations and improve care.

### *Hospitals*

QIOs are providing educational support and information on preventing surgical complications to hospitals under the Surgical Care Improvement Project (SCIP). QIOs also are offering hospitals assistance on collecting data and publicly reporting their performance in implementing clinical processes proven to make surgery safer. QIOs are bringing hospital teams together for collaborative learning sessions; offer hands-on assistance helping teams adopt safer practices, and provide guidance on overcoming barriers to change.

QIOs are also engaging in a patient-centered approach to improve care across multiple inpatient topics using a composite measure, called the "Appropriate Care Measure" (ACM). The ACM combines 10 publicly reported quality measures (five acute myocardial infarction measures, two heart failure measures, and three pneumonia measures) into one rate that provides a more accurate description of how a hospital treats patients across the spectrum of care.

In addition, QIOs are partnering with hospitals to redesign their organizational culture and systems of care -- including the use of computerized physician order entry, barcoding and telehealth -- to boost performance on all of these clinical topics. QIOs also are helping rural and critical access hospitals, through a new rural-focused task, to use telehealth and other technology, collect and submit performance data, as well as identify and resolve gaps in patient safety.

#### **Future QIO Assistance**

As I've outlined today, the field force of QIOs offers health care providers in every state free, necessary assistance for improving quality. From supporting and accelerating physician adoption of EHRs to working with nursing homes, hospitals, home health agencies and others, QIOs are helping health professionals utilize the latest techniques in quality improvement to eliminate medical errors, reduce suffering and improve the quality of life for patients across the country. As HIT, pay-for-performance and health information exchange increasingly become vital tools for transforming quality, all providers will need performance improvement assistance from quality experts like QIOs.

The QIO program represents the largest coordinated federal investment in improving health care quality -- right now, that investment accounts for less than one tenth of one percent of overall Medicare spending. We hope you will strengthen this invaluable program by passing Dr. Burgess' visionary legislation and making the program a central fixture in our collective drive to provide the right care to every patient, every time.

MR. DEAL. Well, thank you all.

I will recognize myself to begin the questions.

Dr. Wolter observed, I believe, that all the physicians agree on one thing, and that is, they ought to get more money. I am shocked. This is indeed a complex issue, and solving it in the short term is certainly a whole lot simpler than solving it in the long term. Unfortunately, over the last several years, we have only tried to do it on a short-term basis, on an annual basis, actually. I would like to talk about a few basic concepts here and sort of see where the group is on it.

I suppose the best place to start might be at the very beginning, which I think the concept of a medical home is one of those beginning points. Does anyone disagree that the idea of establishing a medical home should be a part of whatever future structure we might try to put into place? Does anybody disagree with that?

Then let me move to the second stage of that, because I believe Dr. Wilson and maybe someone else suggested that there may be a medical home concept or at least a coordination of care concept that is appropriate at a level other than just at the primary care level. Dr. Weida, of course, addressed it from the primary care physician side of a coordination of care, and I believe, Dr. Wilson, did you mention that? And someone else did, too. Yes, Dr. Golden. Would you and Dr. Golden comment about that and explain to me exactly what you are talking about?

DR. WILSON. My comments were in the context which suggests that there may be specialties in addition to primary care who could provide a

medical home based on qualifications. One example that comes to mind would be cardiologists providing chronic care for chronic cardiac disease.

DR. GOLDEN. The college recognizes the concept of principal care, in addition to primary care. And there are some patients with complex diseases that see a specialist for 90 percent of their care.

MR. DEAL. And that is where they return to on a frequent basis.

DR. GOLDEN. That is correct. Some oncologists take over all the care of some of the chronic cancer. Endocrinologists often can be very comprehensive. But we believe that whoever serves in this medical home should meet certain criteria, and they should be qualified to serve as a comprehensive home for that patient.

MR. DEAL. That makes sense to me. Does anybody disagree with that? We are confronted with some very different points of view on the same subject matter, and that is reporting of information. I, frankly, am one of those that sort of tends to agree with Mr. Shadegg in terms of, consumers are the ones who can make the choices rather than the government maybe in some artificial fashion trying to make choices for them.

However, we run into a real conflict. And that is, for consumers to be able to make choices, they have to have information. And that is where we sometimes run into conflicts with the medical community, quite frankly, in the reporting of the information that consumers need in order to make good choices. I think everybody understands where I am coming from. And there is a very delicate balance between reporting information that may be able to make good choices--it is a little easier I think in a hospital environment where you can report, you know, so many procedures, average cost for the procedure, number of return visits following the surgery and so forth.

How do we deal with this issue of reporting of information that is going to lead to a meaningful choice, either by a consumer making a choice based on the information that is made available to them, or go to the other side of the model and have the government make a choice based on the information that is reported to the government? Quite frankly, we are all sort of in the latter mode right now. Would anyone care to talk about that? Because I think this reporting issue is certainly an important part of what we go to in the future.

Dr. Thames.

DR. THAMES. Mr. Chairman, I would like to speak to that, and commend the words Dr. Wilson gave from the consortium from the AMA that is working on quality guidelines, so that if we know what to ask in the questions of reporting, this material can be assessed with

guidelines that are set by the specialists who know best what constitutes the best care with the best outcomes for evidence-based medicine.

So he has indicated they already have over--I have forgotten how many--they are going to have 70 more before the end of this year. So I commend them for that work, and I suggest to you that it is a group of knowledgeable physicians who are establishing those guidelines rather than some vague government entity or someone who is not on the front lines who is doing only administrative medicine.

MR. DEAL. I agree with you, and that I think is one of the real concerns about who is establishing the criteria. I think we are pretty much all in agreement that the professions--and I know you all have been working on it in your specialty group in establishing that. I commend you for that. Some are more difficult to establish than others, and I understand that as well. But I think that is a point well made.

Anyone else want to comment? I am out of time, but I will let somebody else respond.

DR. RUSSELL. Mr. Chairman, I would agree that, with some specialties, it is easier. In surgery, I think it is easier in a way. The surgical part has a beginning and an end and a result. It needs to be risk adjusted. So we are very enthusiastic about establishing in hospitals a risk-adjusted system that had actually been done in the VA hospitals in the early nineties. And that is our major thrust at the College of Surgeons--the risk-adjusted measures to look at outcomes, which is a very good way to evaluate surgery: outcome as opposed to processes or structure.

The problem is, of course, a lot of surgery in America is done now in doctor's offices and outpatient facilities, so we then have to take the in-hospital model and be able to bring it into the outpatient surgical arena which is a real challenge, and we are working on it.

DR. GOLDEN. I would like to add that consumers at this point are limited with what they can do with the information. But the accountability of these measures brings about changes at the community level that I think have real impact on quality. So I think one of the things to look at is not necessarily how consumers use it per se but the impact across the community as the information becomes transparent and people are accountable for their performance.

MR. DEAL. Well, I apologize for having to leave you all once again, but I think you agree that I need to go to the conference on trying to work out health IT. We are still hopeful that we are going to get that issue finalized.

I would just leave with one final observation, and I think Dr. Thames and maybe--I know Dr. Thames said this. We are confronted with a



system right now that does not reward quality. In fact, it might even reward lower quality by repeat procedures that may be unnecessary.

There is no financial incentive for the folks who are really making the effort to do the best job. That is sort of like the debate we have had in the education community for a long time. We pay teachers the same thing, whether they are the bottom of the rung or the very best. But you start talking about incentives in education for teachers, everybody goes crazy. Nobody trusts the one who makes the judgment as to what the quality is.

And we are faced with exactly the same situation here. And it is not easy. It is not going to be easy. But I think, for the sake of the citizens of this country and the health care system, on a continuing basis, we need to continue to struggle with it, and I appreciate all of your inputs today.

Mrs. Cubin, are you going to take the--Dr. Burgess is going to take the Chair. I don't know whether to turn it over to Dr. Burgess. He already has the big head from all that you all have said about him. He is certainly qualified.

I recognize Mrs. Capps for her questions at this point, if you will excuse me.

MS. CAPPS. Thank you.

As you leave, Mr. Chairman. I just want to reference one remembrance that came up as the idea of designating a specialist as a care coordinator was asked about, and it reminds me that, a few years ago, we had a bill called the Patient's Bill of Rights that received quite a bit of attention in the consumer as well as the provider community. We got that legislation through two chambers, but it, unfortunately, was not signed into law. It is an idea that has been around for a long time. It is still a very good idea.

I can't help also but referencing, as our Chairman leaves, everyone holds out this ideal of having choices about your physician. That was part of the Patient's Bill of Rights as well. I think that may be a moot point. And I go back to what I commented on in my opening remarks, with the knowledge that there has been such a decline in physicians, family physicians especially.

And Dr. Weida, I want you to expand on some things I brought up. As I mentioned, the prediction of family physician shortages and then address how much of your practice for your group is Medicare patients.

I am a public health nurse, and my focus has always been on primary and preventive care, which is the focus of many in your practices as well. I was astonished to read the number of medical graduates going into family medicine has fallen by more than 50 percent since 1997. I think that is very remarkable and perhaps you could indicate how you see that in the future. What I want to see in light of this hearing is how you

would describe the Medicare reimbursement system; whether or not it plays into this decline.

And also, as you discuss this, if you would talk about the way the number of family physicians could translate that decline into an overall national increase in health care spending because of a decreased availability of primary and preventive care.

If that delays the onset of care by people who can't find a physician close at hand, therefore, the care is more expensive when they do reach it.

DR. WEIDA. Thank you, we have just completed a workforce reform study. That is what you are referring to. What that showed is we will need a 39 percent increase of family physicians to the health care needs by 2020. That is coupled with, as you mentioned, a decline of American medical students from American medical schools going into family medicine. Some of that gap has been filled by international medical graduates. However, overall, it has been very difficult in family medicine. A lot of that is predicated on reimbursement or payment and hassles of payment.

We talk about the pay-for-performance. One of our concerns is if the system is too cumbersome, we will not be able to really do anything about it, because we see a number of patients that have relatively small charges. So that is a major concern for us.

What we do know, and this is from the Barbara Starfield data, is that in States that have more primary care, their health care quality is better and their cost is less. This is on Medicare data. That amounts, and can amount to as much as a \$2,000-per-year/per-beneficiary difference between the States with the best ratios and States with the worst. That is a tremendous difference.

I would be happy to get you copies of our workforce reform report, if you would like. It is a State-by-State analysis, and we would certainly be happy to provide this committee with this report as it seems you have quite an interest in that.

MS. CAPPS. We could actually access it too. I think it would be good. If we could request your statement then--as it reflects this topic.

I only have a couple of seconds, there might not be time to do this. But Dr. Thames, I wanted to get to the topic of so-called balanced billing. In the 1980s we passed protections, because doctors who were accepting Medicare began charging more so as to, as they call it, balance the billing. The legislation has been referred to this committee. It is a related topic that would lift the balanced billing protections.

I wonder if AARP would support a balanced billing protection staying in place and what concerns would you have about such an action?

DR. THAMES. Well, we are very concerned about balanced billing without limitations. I am one of those physicians who practiced before 1989 when limits were put on there. I am aware and AARP is aware of evidence, much evidence of very excessive billing, and we would not support doing away with a limit on billing. We believe that it will raise the costs excessively. It will make health care costs go up. It doesn't do anything for health care reform, and this is what I think this committee is looking at: payment and health care reform and trying to contain costs.

We feel that having a limitation on the billing--balanced billing is important.

MS. CAPPS. Thank you, I have overextended my time. Thank you.

MR. BURGESS. I thank the gentlewoman for yielding back. I will recognize myself for such time as I may consume. I mean, 5 minutes for questions.

We need to stay on that concept of balancing billing for just a moment, if I could. The gentlewoman referred to them as protections. I had actually referred to them as restrictions. Now in the Medicare Modernization Act that we passed one morning in the last Congress, we referred to--we weren't allowed to use the words "means" and "testing" together in a sentence, but we did use the word income, relating to Part B premium, together in a sentence.

If we tied the balanced billing provisions to those levels that have already been set by the income relating to Part B premiums, we have already identified those individuals who could afford more for their medical care. Why restrict them from their doctor of their choice, if they are willing to pay a portion of their fee? Is that a fair thing to do?

DR. THAMES. You know, again, I am going to go back to personal experience. When I went into practice, we didn't have Medicare.

MR. BURGESS. That is correct.

DR. THAMES. And we had poor people that we delivered care to as physicians, and if they had something they grew they wanted to give you, they did. We charged more to bankers and others. You know, it never was easy for me to decide how much I ought to charge someone else, because even if he was an attorney, if he was young, how many children did he have, how many of them were in college, the other things, I didn't know what was fair in billing.

So, personally, I am one of the physicians who, when the 1989 restriction was put on there to balance billing, and I didn't accept--and I was a participating physician and I didn't accept the balanced payment--but I was glad to see some restriction put on there.

I don't, personally--would not want to try to assess what people can pay in balanced billing, because I don't know what the bottom line is for 1044. As a physician, I want to be paid for what I do for the patient.

MR. BURGESS. So it is better to have the government make that decision than you--

DR. THAMES. It is better to have some, I think, finite number about how much is correct, which is what we did in 1989.

MR. BURGESS. If I may interrupt, the finite number exists. What we are talking about is, usually customary, the Medicare maximum allowable fee table. I am going to run out of time. We could debate this into next week.

MS. CAPPS. We should have a hearing on this.

MR. BURGESS. I would be happy to recommend to the real Chair we have a hearing.

Before I run out of time, I would like to ask Dr. Elston, I think you referenced this, your home is in the great State of Pennsylvania.

DR. ELSTON. Yes, it is.

MR. BURGESS. We love our friends from Pennsylvania. Do you have an opinion as to whether or not, when we did not fix the SGR decline January 1--we thought we had, and then on a technicality we were put into overtime and it didn't get fixed, so on January 1, Medicare rates go down--what was it, 4.4 percent--do you have an opinion as to whether or not that affected your State's reimbursement for private insurers?

DR. ELSTON. Yes, it didn't help.

MR. BURGESS. Do private insurers peg their prices to Medicare in the--

DR. ELSTON. Yes, we see in rough proportion, yes.

MR. BURGESS. So there are, in a sense, Federal price controls on the practice of medicine as it exists today, even in the private sector?

DR. ELSTON. Yes.

MR. BURGESS. Now, I know Dr. McClellan quickly stepped up to the plate and said you guys won't even have to resubmit those bills, we will get that update to you quickly, as soon as Congress passes it and as soon as the President signs it. How quickly were the private insurers coming to you with their additional checks for moneys that were inappropriately withheld between January 1 and February 4?

DR. ELSTON. It may shock you, but they were not lining up at the door to do that.

MR. BURGESS. It doesn't shock me. Does anyone even know in their practice if that has even happened to this day? Those are small amounts of money, it is difficult to track. But it is a small amount of money on each patient; cumulatively, it is a significant amount of money.

DR. ELSTON. It is. I know it was a concern to our organization, and it was very difficult, and difficult with each of the different payers to communicate and to track. To my knowledge, we have recouped little.

MR. BURGESS. Dr. Golden, if I could ask you, it is a shame our Chairman had to go to the conference on health IT, because I think he really should have heard you talk and the other QI organization's opinions about health IT. When you guys in Arkansas--you do a great job of helping the individual physicians' offices with these decisions and these types of purchases; is that not correct?

DR. GOLDEN. We are one of the demonstration States. In fact, we got involved, we had the ACP help us, a consultant in that activity as well. But we had in a rural State, over 174 different practices, hundreds of our practice sites, sign up to learn about practice redesign and how to go about assessing their practice and going about the purchasing of HIT.

MR. BURGESS. Dr. Cook, in your written testimony, you did discuss it, but you had about the literature and experience, about half as many as all IT health implementations fail for one reason or another, often because practices don't go through rigorous development necessary for success.

In Utah, one clinic had been using their EHR system for 7 years but had never turned on the clinical decision support or disease management functions. That it seems is almost unbelievable.

DR. COOK. We are encountering more and more of those types of scenarios where physicians may have purchased systems that may not be using part of it--the billing part or some--but not exercising the rest of the system.

MR. BURGESS. Now, Mr. Deal is in a conference right now that is going to place these systems in every physician's office in the country. You are telling us from your experience, they may not be getting value for their dollar if they do that.

DR. COOK. Well, the point we would like to make is that the quality improvement organizations are working with physician practices to help them understand how they can best use HIT.

MR. BURGESS. My time is up. I hope you packed a lunch, because you are going to have a lot of work ahead of you.

DR. COOK. We do. We are underfunded to do this work. We are only working with a very small number of practices. In Virginia, for example, we are working with 200 physicians who are in primary care. We have 16,000 licensed physicians in our State. So that tells you, we are making a very small dent in the technical assistance we are able to provide.

MR. BURGESS. Thank you. I will recognize the gentleman from New Jersey. If I could, unless there is an objection, we may go to a second round of questions.

MR. PALLONE. Sure. I just want to thank you, Mr. Chairman.

There is some interest--this is for Dr. Thames-- there is some interest in legislating a new utilization management program in Medicare where State-based organizations would review a physician's practice pattern and compare it to its peers. The goal, obviously, to inform doctors when they are providing too many services for a particular illness, and another doctor is in the same specialty, you know, encourage them to cut back. That might be, you know, obviously the motivation.

But what I worry about is, if designed improperly, such a program would provide the wrong incentives to doctors to cut back on needed services and negatively affect patient care. There are a lot of reasons one physician may be providing more services to his patients than another.

Perhaps a doctor treats more patients who are sicker or patients with multiple chronic conditions. Perhaps a doctor works in conjunction with a trauma center where injuries are more severe. There are a lot of possibilities.

If a utilization results in penalizing a doctor just because they provide some more service to what is right for an individual patient, we might be setting a bad incentive. I wanted to ask you if you would comment on keeping the patient as the central focus to any changes in Medicare physician payment systems, and what dangers do we have to watch out for if Congress were to move down the path of utilization review?

DR. THAMES. First we are, and our primary focus from AARP is that quality care and patient care should be the primary and most important focus in the whole program. Having said that, we believe that with the use of proper medical specialties and proper guidelines, we can look at utilization management and we can decide, like in chronic disease cases, that there are certain things that you do which lead to better outcomes, less emergency room visits, less hospitalizations.

Now we recognize that there are physicians who will have a higher percentage of very complicated cases, or have a lot of patients who are not very compliant, so that when you begin to look at utilization of services, they will be outliers, and those kinds of outliers--and there are those outliers who use inefficient practices or just aren't knowledgeable enough to do what the guidelines called for. Or don't do them. Those are two different things.

So you have to work out risk adjusters to be sure that those outliers who are doing very complicated cases are not penalized by the utilization management. That is one of the reasons we don't have all of the tools for

the risk adjustment available through medicine today. We are developing those in some specialties better than others, but that is why AARP has said we want reporting to go first, and then we want to look at the pay-for-performance and the utilization management that goes with it, to have those risk adjusters that are based on solid medical evidence.

MR. PALLONE. Thanks. All right, I would like to ask some of the other panelists--I guess I can't ask them all because there are so many--about the whole risk adjustment phenomena; in other words, whoever wants to comment. Would you agree that Congress should guard against the prospect of utilization review inappropriately penalizing doctors who treat sick patients or have a different doctor-patient risk?

What do you think about this idea of a risk adjustment in a payment system? Do you think we need it? Is a good way to adjust for risk? How long will it take, or how easy it is to develop one? Dr. Wilson.

DR. WILSON. I think what you are addressing is how complicated this all is, and risk adjustment is only one part of that. Certainly the answer to the question, you said of course, we do think risk adjustment is critical for whatever you do in terms of reporting.

The other thing is just sample size. You know, if you are evaluated--and our hospitals have been doing this for years--and if you are evaluated on a quarter on the pneumonia patients, and you only had two that quarter, it is hard to imagine that reflects the kind of sample size that gives you good information about where you might rank in comparison with your peers.

So the challenges are there, and that is the concern physicians have; not that we don't think that information is going to be helpful, but when you get the information it needs to be information that is going to be valuable and valid because of those things.

MR. PALLONE. I don't know if we will get through all of them, but Dr. Morris.

DR. MORRIS. Yes. Not only in terms of the sample size you need to be concerned, but you also need to be concerned about the patient populations that are included in the information that we get. Those of us who see patients with a greater disease burden that was already described--sicker patients with multiple morbidities--it becomes very difficult to make sure that if a patient has socioeconomic restrictions that does not allow them to get their medication, versus a neighborhood that they live in where their healthy living isn't a priority and therefore they are not getting their exercise and they are not doing all the other things they need to do in order to maintain appropriate health, that we take that into consideration, and the physicians who treat these populations.

MR. PALLONE. Thank you. My time is up. I don't know if you want to continue with that.

MRS. CUBIN. [Presiding.] Yes, it is. It is all right with me if you would like to continue.

MR. PALLONE. There are a couple others. Why don't a couple others of you answer?

DR. RUSSELL. I would simply like to say in answer to your question, physicians who do surgery or procedures, if you don't risk adjust, you will create perverse incentives which will be very, very unacceptable and will be discriminatory against certain patients.

Doctors just won't touch high-risk patients. They won't do surgery on patients that need to have it done, because they are too high risk.

Unless you recognize that with a good solid means of risk adjusting, then I believe you will create these perverse incentives.

MR. PALLONE. Sure. Dr. Cook.

DR. COOK. If I might add, just to add to the comments that have already been made, which I agree with, I believe that in addition to having rigorous methodology--which includes having valid information, timely and peer-grouped information, and those sorts of methodological issues--it is also possible to combine utilization information, workforce quality information, and that produces--efficient information so if, for example, you want to look at end-of-life issues and appropriate utilization of services at that time to ensure good quality of care, good coordination of care, I think there is a lot of room for development of good efficiency measures in addressing some of the issues.

MR. PALLONE. Okay. We have one more, then we will finish. Go ahead, Dr. Martin.

DR. MARTIN. I wanted to comment. I think what everyone is talking about, here is the difference of what we are looking at. Generally what we are looking at is claims data and what we really need to move to is clinical data, if we have a system that looks at clinical data, which will be much more affordable, if we in fact have good health information technology, not adjust for that patient compliance, severity of illness, risk adjustment, patient, things like that. So we need to move away from claims and we need to go more to clinical data.

MR. PALLONE. Claims data, you mean in conjunction with a suit? What kinds of claims?

DR. MARTIN. If a patient has a diagnosis of congestive heart failure, we give that a score. Or we look at the risk utilization or risk management. However, that patient that has got congestive heart failure may say, I am on four medicines, I am not going to take the fifth medicine. We would know that from the clinical data, not from the claims data.

DR. GOLDEN. Claims data being billing information.



DR. ELSTON. Right. And specific CPC category 2 codes are designed to capture performance data.

MR. PALLONE. Thank you very much. Thank you, Madam Chairwoman.

MRS. CUBIN. Please excuse our musical chairs up here. Everyone is busy trying to finish up before we go into recess.

I want to talk about something that isn't exactly the subject that the hearing was called for, but it something that I think is very important; and, as Dr. Weida discussed, how important it is to have primary care doctors, or someone who is able to take care of a doctor, be the quarterback most of the time, if not a family practice or internist, how the fact that we--factors, I should say, that contribute to not being able to get primary care physicians.

I represent the State of Wyoming. I have a husband that is a physician, now retired, and a son that is a physician. I know that it used to be that rural areas, number one, weren't reimbursed at the same level that urban areas were reimbursed. We have tried to fix that because, you know, the effect of that was when these people would get out of medical school, they would have the same amount in student loans that they had to pay back.

They had to pay the same amount for equipment; that office space might have been the only thing that might have been a little bit cheaper. But if you live in Jackson Hole, Wyoming or Sheridan, Wyoming, it would be higher than the national average. So that was something that made it less likely for primary care, or any physicians, to want to come to rural America.

Well, now another factor, I think, is the fact that primary care physicians are basically reimbursed at a lower level. Cognitive medicine isn't recognized to be as valuable in dollars as technical practice. I am not trying to pit one against the other because I have a son who is an intervention radiologist and a husband who is an internist, so I don't want to take sides.

But in our newspaper today, there was a story about the need for primary care physicians in Wyoming, the State that I represent. I guess I would pose this question to Dr. Thames: In your testimony you mentioned the often predicted but rarely seen specter of physicians refusing to see Medicare patients if rates do not rise.

Now, I assume that is a nationwide picture that you are painting, because I know in rural Wyoming that doctors don't take Medicare patients anymore, for the most part. Some do because they are generous and they can. But I don't know any that refuse to see a Medicare patient if the patient has been in their practice a while.

But are you troubled, nonetheless, by the effect of that access to care, due to the impending schedule of payment cuts? Are you concerned about that?

DR. THAMES. Madam Chairman, I would have to say that my testimony did not address that. But I would tell you from AARP, we are concerned about access to care. I do have family practitioners, as I was still in practice, doing that; and they would not refuse to see those patients who are already their Medicare patients.

But they would, as has been indicated, decide whether they would take any new ones; and if so, how many could they afford to have. Now, someone who actually said that in their testimony may be able to identify that, may be able to answer a question otherwise.

MRS. CUBIN. Do any of you have a feeling about the reimbursement rate for special cognitive disabilities being reimbursed at a lower level than the other specialties? Anyone who would like to respond. I would like to hear from Dr. Wilson. Do you want to start?

DR. WILSON. Thank you, as one of them, a cognitive physician.

MRS. CUBIN. Right.

DR. WILSON. It is a different world now. First of all, I really enjoy what I do. I like being an internist. I like seeing patients.

The reality, though, of the reimbursement world now is that if I were starting my practice, and I had a mortgage and I was going to be raising children, if I were smart it would be--I would choose a different area of medicine to practice in. Just the economics of it.

That is one of our concerns. And we are already seeing that in bright medical students who make choices other than primary care based in part, not solely, on reimbursement; based also on a desire to have a certain life-style in terms of your own time with your family and those kinds of things. But they are making those choices.

Our concern for the long run, and I think certainly ACP and Dr. Golden are on that track, is that in the long run, if medicine becomes even more unattractive in terms of the financial rewards or compensation, then these bright young people who are choosing medicine would then start choosing other equally good professions where the rewards are greater.

DR. GOLDEN. Let me follow up. Can I follow up on Dr. Wilson for a second?

MRS. CUBIN. Another thing that weighs in on your point, I think, is that in rural areas, primary care physicians don't have someone to take calls for them, and so the quality of life for their family is really difficult.

Dr. Golden.

DR. GOLDEN. Yes, very quickly. One of the things we have seen is that the office visit has changed. We get paid in primary care for when

you are in the office. Increasingly, a lot of activity is between visits. We have no--there is no incentive to do e-mails, to follow up and see if Mrs. Jones is taking her medicine, so it is hard to do continuity in that regard and do outreach.

The other piece is that we can talk about access now, the attractiveness of the career has really deteriorated. We are talking 5 or 10 years from now--in internal medicine, in my program in Arkansas, we used to graduate eight or nine residents a year who would go into office practice. We are now graduating one. This is international graduates and American graduates.

So we are not building my replacement for the future while the population is aging. This is going to be a big problem in the very near future.

MRS. CUBIN. That is right.

Dr. Martin.

DR. MARTIN. But at the same time, I want to also recognize the RUC Committee of the AMA who did review the cognitive value of our office visits and have made the recommendations which should be approved by CMS to increase some of the payment for cognitive value for our visits. Some of the codes may be going up as high as 37 percent on the physician work component. There is some recognition there. That was through the 5-year review--again, that may come up in 5 years, which may help us again.

MRS. CUBIN. Is that the adjustment that was made on the backs of the radiologists? I heard all about that.

DR. MARTIN. Well, all of these adjustments have to be budget neutral. So, in fact, if there is going to be a specific increased payment, it has got to come from someplace else. What CMS has said is they will look at the work component of the physician and take 10 percent away, so that 37 percent, for example, on level 3 E&M code, may be only a 34 percent in the E&M code for the physician work component. That was a way that you had to take it away. Rather than adjust it at the conversion factor level, CMS is choosing to adjust it at the work level of the physician, across the board, of all physicians.

MRS. CUBIN. Dr. Russell.

DR. RUSSELL. Thank you very much. After practicing surgery in San Francisco for 30 years, there is a lot of cognition in surgery, too; it is not all just technical.

MRS. CUBIN. Sure.

DR. RUSSELL. You get referred some difficult cases that you ought to think through whether you ought to even do the surgery or not. So it is not black and white on this issue.

MRS. CUBIN. No, issues never are.

DR. RUSSELL. Yes, exactly. Also, having a daughter in medical school now, which I am extremely pleased about, the reimbursement is very, very important as far as what direction people take. Because I am sure, as you all know, people are finishing medical school now with about \$150,000 in debt, and there is no question that what you are setting up today with reimbursement policies is going to have a real effect on the workforce 5, 10 or so years from now.

I think what Dr. Golden has experienced is a very real thing. It makes me wonder about primary care and who will be doing primary care in the future. Will it be physicians or will it be nurses or physician assistants? So this is a very important issue which you are considering. It has long-term implications.

MRS. CUBIN. Dr. Weida.

DR. WEIDA. Yes. The RUC update certainly is well appreciated by family medicine, and we appreciate all colleagues who participated in that process. But I think part of the solution to what you are asking about goes back to the creation of the personal medical home and having payment for the personal medical home based on a per month, per member--per-member, per-month reimbursement. Because that takes it out of this, you know, fight of one specialty versus another, but puts it in the realm of providing service to the Medicare patients that can extend just beyond a visit. Because a current CPT coding is primarily visit-based coding. It is not care-based.

I think if we have a personal medical home and a payment system that reimburses that, that then provides incentives to really expand the care to the elderly. Because for many elderly, transportation to an office is an issue. This way we can start looking at electronic communication and really be very helpful and take the care to where the home is and to where the patient is. So I really think that is a critical piece, if you are looking at redesigning the future, that really makes an impact.

MRS. CUBIN. Thank you.

DR. MORRIS. One more, please.

MRS. CUBIN. Yes.

DR. MORRIS. Thank you for recognizing me. I just wanted to say in that same vein, that one of the reasons primary care is important in our organization is because our doctors are twice as likely to go into primary care. African physicians and minority physicians are twice as likely to go into primary care than other groups in this country, and we are five times more likely to go to underserved communities to serve those communities.

So I think increasing the number of African American and minority physicians in this country is another strategy that was used back in the

1960s to increase the number of physicians in this country in primary care.

MRS. CUBIN. Well, Wyoming needs you both for the reason that you just mentioned, but also because we need more minorities, seriously.

I thank you. Now, if the panel would like to do a second round I would be willing to stay for that. Do you have time?

DR. ELSTON. This is important to us. We will take whatever time it takes.

MRS. CUBIN. By the way, Dr. Burgess had a question that he wanted me to ask. He would like to know your opinions regarding silos, funding silos in Medicare. He would like to ask you to respond to that in writing to his office, if you would do that.

The record will remain open for 7 legislative days. So that is going to be quite a while, since we will be leaving tomorrow. Anyway, he would appreciate that response.

If the panel has time for one more, I won't ask any further questions. Lois, did you have any further?

MS. CAPPS. I was actually very interested in this round--that you were initiating to my colleague, Barbara Cubin. The underserved areas and the rural areas have been a big source of concern for many of us who have large populations where the reimbursement formulas are way, way out of whack. We are seeing difficulty with primary care physicians who will take Medicare, or going out of medicine, transferring to a different setting like a prison or some kind of institution.

You know the heart and soul of medical practice is the doctor's office or clinic and whoever is providing it, because the number of people in acute care, there is only a certain percentage at a certain time in their life.

If we are really going to talk about delivering health care, we will have to talk about you folks, Dr. Weida and others, in attracting people to rural areas.

I think that is a whole different topic for discussion. Certainly, I would urge that Mr. Deal be convinced that we have a hearing, with all of you coming back and going into this other area.

We have to catch up to the 21st century of where medicine should be. One of the things really is the cuts in Medicare that is primary. We all know we need to do that. That was why I was rather impatient in the beginning, but there is so much else that you all are so good at expressing that we should really listen to.

We need to have this follow-up, particularly with Wyoming and rural America at the heart and soul--not that it is just there--there are urban areas, underserved areas, minority communities have the same problem.

There is no area that is actually immune to this now. I think we are seeing a train wreck coming with the aging population.

MRS. CUBIN. Thank you. Dr. Elston.

MS. CAPPS. I started something.

MRS. CUBIN. That is okay. I would like to give you the opportunity to close.

Dr. Elston.

DR. ELSTON. We are a rural State. I practice in a very rural area. We have an aging demographic. We are, I believe, the oldest State per capita in the Nation right now. And, absolutely, the reimbursement is driving physicians--making it very difficult for them to return to rural areas after their training.

I am here today representing the Alliance of Specialty Medicine, and you raised the question about cognitive and the concern for people not going into primary care fields. We share the concern as well. It is a concern for all of us. It really scares me who is going to take care--who will be the internists in the next generation.

We share concern for patient care, and the issues of reimbursement and fair and equitable reimbursement affect every one of us and our patients.

MRS. CUBIN. Dr. Martin.

DR. MARTIN. I would like to make a comment both from my organization, the American Osteopathic Association, as well as for my State, the State of Ohio. I mentioned that we had 59,000 members in the American Osteopathic Association. Of those 59,000 members, 25,000 of those are in primary care, and specifically the American College of Osteopathic family physicians, so we have got 25,000 family physicians.

It has been the tenet of the Osteopathic Association to set up schools in rural areas and develop physicians who will go to the rural areas to practice an in underserved areas.

I can tell you also in our State of Ohio, the Ohio University College of Osteopathic Medicine, the tenet for its starting was basically to provide physicians to serve those underserved rural areas.

We always used to always graduate--so I am talking about 5 years ago, not a long time ago, 70 percent of our people would go into primary care. That would be family practice, internal medicine, pediatrics, or OB/gynecology. I will use the Federal definition of all four.

Now the proportion has dropped to under 50 percent. So the rural areas, those underserved areas that the osteopathic professionals provided physicians for, we are no longer getting those physicians, or the interest in those students who are coming through to go into those areas.

Again, a lot of it has to do with what other panelists brought up, with the debt these people are coming out of school with; what are the proportions of payment that they will receive in future years.

I do want you to make consideration for that so we do, in fact, take care of those areas that are rural, underserved. Thank you.

MRS. CUBIN. The reasons that you discussed are exactly the reasons that my son first chose to go into radiology. Then he said, Mom, I have got to be somebody's doctor. Then he decided to give up the quality-of-life issues and go into the interventional aspect of it.

But I would like to ask one thing to help me convince Chairman Deal that this might be the subject of another hearing, although he will never let me have the gavel again, since I have done this. Is there anyone who thinks that the issue we have just been discussing wouldn't be worthy of it? Or how many think it would be worthy of a hearing on its own? Thank you.

As I stated earlier, the legislative record will be held open for 7 days, and we would respectfully request that you answer any further questions that committee members have to submit to you. Thank you so much for being here and being patient with us.

The hearing is adjourned.

[Whereupon, at 4:48 p.m., the subcommittee was adjourned.]

